	Form20.Participant Intake Form	
Doc No: Form20	**Version No: 01**	**Version Date: 28/09/2024**

Date:

Personal Details

Surname:	Given name(s):	Sex : ☐ Male ☐ Female ☐ Intersex or Indeterminate ☐ Prefer not to say

Are you an Aboriginal or Torres Strait Island descent? ☐Yes ☐No

Preferred name:	Date of Birth:

Residential Address Details		**Postal Address Details**	
Number / Street:		Number / Street:	
State:	Postcode:	State:	Postcode:

Contact Details

Email address:

Home Phone No:	Mobile No:

NDIS Information

NDIS Number:	Plan review date(Must be reviewed annually):
NDIS Start Date:	NDIS End Date:

Funding : ☐ Plan managed ☐ Self-managed ☐ NDIA managed ☐ other ----------

Are you registered with another NDIS provider? ☐ Yes ☐ No

If Yes, please Specify the service you are receiving with the NDIS provider:

Diagnosis or Health Concerns

	Form20.Participant Intake Form	
Doc No: Form20	**Version No: 01**	**Version Date: 28/09/2024**

Advocate / Representative Details (If applicable)		
Surname:	Given name(s):	Relationship with participant:
Phone No:	Mobile No:	Email:
Address Details:		
Postal Address Details:		

Other Information	
Country of Birth:	Number of years in Australia (if not born in Australia):
Main language spoken at home:	Is a language Interpreter required? ☐ Yes ☐ No

Are there any cultural, communication barriers or intimacy issues that need to be considered when delivering services?

☐ No ☐ Yes please indicate below:

☐ Verbal communication or spoken language - Is an interpreter needed? ☐ No ☐ Yes Language:……

☐ Cultural values/ beliefs or assumptions:……..

☐ Cultural behaviours:……..

☐ Written communication / literacy:……..

Physical Profile

- **Weight:**
- **Eye Colour:** ☐ Brown ☐ Hazel ☐ Green ☐ Blue
- **What is your build?** ☐ Small ☐ Medium ☐ Large
- **Facial Hair?** ☐ Yes ☐ No
- **Birth Marks?** ☐ Yes ☐ No
- **Tattoos?** ☐ Yes ☐ No

- **Height:**
- **What is your complexion?** ☐ Fair ☐ Light ☐ Olive ☐ Dark
- **Hair Colour:** ☐ Brown ☐ Blonde ☐ Red ☐ Black ☐ Grey ☐ Bold

Emergency Details (Primary Contact)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:

Emergency Details (Secondary Contact)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:

	Form20.Participant Intake Form	
Doc No: Form20	**Version No: 01**	**Version Date: 28/09/2024**

GP Medical Contact	
Clinic Name:	Email Address:
Surname:	First Name:
Address:	
Telephone Number:	Mobile Phone Number:

Specialist Medical Contact	
Do you see a Specialist for a medical condition/disability? ☐ No ☐ Yes	
Clinic Name:	Email Address:
Surname:	First Name:
Address:	
Telephone Number:	Mobile Phone Number:

Living and Support Arrangements

What is your current living arrangement? (Please tick the appropriate box)

- ☐ Live with Parent/Family/Support Person
- ☐ Live in private rental arrangement with others ☐ Live in private rental arrangement alone
- ☐ Aged Care Facility ☐ Owns own home
- ☐ Mental Health Facility ☐ Lives in public housing
- ☐ Short Term Crisis/Respite ☐ Staff Supported Group Home
- ☐ Hostel/SRS Private Accommodation ☐ Other, please specify

Travel

How do you travel to work or to your day service? (Please tick the appropriate box

- ☐ Taxi ☐ Pick up/ drop off by Parent/Family/Support Person
- ☐ Transport provided by a provide ☐ Independently use Public Transport
- ☐ Walk ☐ Assisted Public Transport
- ☐ Drive own car ☐ Other, please specify:

Signature		**Date**	