Participant Referral and Intake Form

*Please complete the following details and email it to* *admin@bloombehaviour.com.au*

# Participant Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | DOB: |  | Gender: |  |
| Contact Details: |  | Email: |  |
| Mobile: |  | Home: |  |
| Language spoken at home: |  | Interpreter required: | Yes ☐ No ☐ |
| Preferred option for communication: | Email ☐ Phone ☐Text ☐ | Do you identify as Aboriginal or Torres Strait Islander? | Yes ☐ No ☐ |
| Residential Address:  |  |
| Postal Address:(if different) |  |

Is there a Guardianship order in place? Yes ☐ No ☐

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there another Behaviour Support Place in place? Yes ☐ No ☐

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Parent/Guardian 1: |  | Primary Carer? | Yes ☐ No ☐ |
| Phone Contact: |  | Lives with Participant? | Yes ☐ No ☐ |
| Relationship to Participant: | Parent ☐ Guardian☐Caregiver ☐Other☐ | Emergency Contact? | Yes ☐ No ☐ |
| Residential Address:  |  |
| Postal Address:(if different) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Parent/Guardian 2: |  | Primary Carer? | Yes ☐ No ☐ |
| Phone Contact: |  | Lives with Participant? | Yes ☐ No ☐ |
| Relationship to Participant: | Parent ☐ Guardian☐Caregiver ☐Other☐ | Emergency Contact? | Yes ☐ No ☐ |
| Residential Address:  |  |
| Postal Address:(if different) |  |

# Disability / Medical Conditions

Including any diagnosis if relevant

|  |
| --- |
| 1/ |
|  |
| 2/ |
|  |
| 3/ |
|  |

Is there a prior Behaviour Support Plan in effect? Yes ☐ No ☐

If so, please attach.

# Other Service Providers

*Include school/work here if applicable*

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone/Email: |  |
| Frequency of use: |  |

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone/Email: |  |
| Frequency of use: |  |

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone/Email: |  |
| Frequency of use: |  |

Please attach all reports from the past 3 years.

*A confidentiality consent form will need to be provided to allow communication for other stakeholders.*

# Health Care Information

|  |  |
| --- | --- |
| Doctor Name: |  |
| Address: |  |
| Phone Number: |  |
| Is there any medications | Yes ☐ No ☐ Please List:  |

# Funding

|  |  |
| --- | --- |
| NDIS Number: |  |
| Is your plan under the PACE system? | Yes ☐ No ☐  |
| Current NDIS Plan Dates: |  |
| Funding allocation: | Specialist Behaviour Intervention Support |  |
| Behaviour Management Plan Inc. Training |  |

Self-Managed ☐ Plan Managed ☐ NDIS Managed ☐

Please provide details for invoices, if not NDIS Managed

|  |  |
| --- | --- |
| Name: |  |
| Email: |  |
| Comments: |  |

# Preferences

|  |  |
| --- | --- |
| Preferred Name: |  |
| Religious Requirements: |  |
| Cultural Requirements: |  |
| Communication Requirements: |  |
| Physical Assistance: |  |
| Other Considerations: |  |

# Goals and Aspirations

|  |  |
| --- | --- |
| Why are you seeking behaviour support? |  |
| What do you want to achieve for yourself – daily living skills, physically, socially, emotionally? |  |
| Immediate Goal |  |
| In the next 6 months |  |
| In the next year |  |
| What are your behaviours of concern? | 1/ |
|  |
| 2/ |
|  |
| 3/ |
|  |

Please also provide your NDIS goals:

|  |
| --- |
| 1/ |
|  |
| 2/ |
|  |
| 3/ |
|  |
| 4/ |
|  |
| 5/ |
|  |

Do you have any further questions or comments?