2 Alice Street, Walkervale, QLD., 4670
Phone: 0481 553 389
Email: amber.fuller@trucaresupports.com

New Participant Intake Form

***Required**

1. Participant Details					
*First Name:		*Last Name:			
Preferred Name:		Prefix (Ms, Miss, Mr etc):			
*Phone Numbers:		Date of Birth:			
*Email Address:					
* Residential Address:			State:	Post Code:	
Postal Address:			State:	Post Code:	
Religion:		Gender Identity:			
Language at home:		Cultural Identity:			
Do you identify as Aboriginal or Torres Strait Islander? **YES** ☐ **NO** ☐		*Preferred option for communication: **Phone** ☐ **Text** ☐ **Email** ☐			
Primary Disability:					
Secondary Disability:					

2. Contacts					
Contact 1			***Contact 2***		
*Name:			Name:		
*Relationship to Participant: Parent ☐ Guardian ☐ Emergency Contact ☐ Next of Kin ☐ Plan Nominee ☐ Other:			Relationship to Participant: Parent ☐ Guardian ☐ Emergency Contact ☐ Next of Kin ☐ Plan Nominee ☐ Other:		
*Phone Numbers:			Phone Numbers:		
Address:			Address:		
	State:	Post Code:		State:	Post Code:
Email:			Email:		

3. NDIS Details			
*NDIS Number:		*Plan Dates:	Start: End:
*Funding Management: Plan Management ☐ Agency ☐ Self-Managed ☐			
***Plan Manager** *(If applicable)*	Name:		
	Company:		
	Phone:		
	Email:		
***Support Coordinator** *(If applicable)*	Name:		
	Company:		
	Phone:		
	Email:		
Other	Name:		
	Company:		
	Phone:		
	Email:		
NDIS Goal 1:			
NDIS Goal 2:			
NDIS Goal 3:			
NDIS Goal 4:			
NDIS Goal 5:			

4. Medical Details			
Doctors Surgery:		Phone Number:	
Regular Doctor's Name:			
Address:		State:	Post Code:
***Known Allergies:**		Do you have an Allergy Management Plan? YES ☐ *(If YES, please provide a copy)* NO ☐	
Do you have any Care Alerts TruCare Supports should be aware of for your safety? *(Example: falls risk, seizures, asthma, anaphylactic, diabetes, etc.)* YES ☐ *(If YES, please specify)* NO ☐			
Do you require assistance with Medication Administration/Management? YES ☐ NO ☐			
Do you require any PRN medications? *(Medications taken 'as needed' are known as PRN medication)* YES ☐ NO ☐			
Do you have any Specialist Assessments you would like to share with TruCare Supports? YES ☐ *(If YES, please attach with this form)* NO ☐			
Regular Pharmacy:			
Address:		Phone:	

5. Health Care Providers *(eg. Allied Health)*	
Name:	Name:
Organisation:	Organisation:
Phone:	Phone:
Email:	Email:

Name:	Name:
Organisation:	Organisation:
Phone:	Phone:
Email:	Email:

6. Support Preferences

*Support Type:

- ☐ Assisted Daily Living
- ☐ Community Access
- ☐ Yard Care
- ☐ Capacity/Skills Building
- ☐ Centre-Based Activities
- ☐ Transport

Other:

Support Ratio: Individual or Group Support?

- ☐ Individual Support
- ☐ Group Support
- ☐ Both

Do you require Accommodation Support?

- ☐ YES
- ☐ NO

Do you want Support on Public Holidays?

- ☐ YES
- ☐ NO

*Preferred Days	Type	Times: Start	Finish
☐ Monday			
☐ Tuesday			
☐ Wednesday			
☐ Thursday			
☐ Friday			
☐ Saturday			
☐ Sunday			

7. Support Requirements

Lifestyle Support Needs: *any areas of your life you may need assistance in, for example, household tasks, transport, meal preparation, budgeting/handling money, mobility, coping with change, planning outings, road safety, community safety and what level of assistance you need in these areas)?*

Communication Support Needs: *(example; do you need assistance with understanding or making yourself understood by others, how do people know how you are feeling, what are the best ways to help you to understand what others are saying to you, do you have any tools to assist you with communications)?*

Personal Care Support Needs: *(example; bathing, dressing, eating, toileting, managing incontinence)?*

Assistive Technology/Medical Supplies/Consumables: *(examples; mobility aids, modified appliances, incontinence aids, tube feeding supplies)?*

Behaviour Support Requirements: *Do you have a Positive Behaviour Support Plan?*

- ☐ YES *(If YES, please provide a copy)*
- ☐ NO

8. About You
Your Likes:
Your Dislikes:
Anything else you would like TruCare Supports to know about you:

9. Attached Documents: *(please list any documents attached to this form)*
1.
2.
3.
4.
5.
6.

10. Consent to Release and Obtain Information

TruCare Supports may need to collect and disclose personal information to third parties (as required) to provide improved care.

You give consent to the following services for TruCare Supports to release and obtain your information:

- ☐ GP
- ☐ Allied Health Services you attend or need a referral for
- ☐ NDIS and your Local Area Coordinator (LAC)
- ☐ Support Coordinator
- ☐ Other

I understand that TruCare Supports must comply with relevant privacy laws and I will contact the organisation immediately if I feel these laws have been breached.

Participant Full Name:	**Participant Signature:**	**Date:**
Legal Guardian or Representative Full Name:	**Legal Guardian or Representative Signature:**	**Date:**

11. Declaration

By signing below, I hereby acknowledge:

- I have completely read and fully understand TruCare Supports 'Participant Profile' and I also affirm that all the information provided is truthful.
- TruCare Supports will not disclose any of your personal information provided, without your prior consent.
- The information TruCare Supports collects is used to provide services to participants:
  - Support in a safe and healthy manner/environment
  - To ensure that individual requirements are both acknowledged and met
  - To fulfil Duty of Care requirements whilst providing supports
  - To enable appropriate referrals to other providers where required
  - To conduct business activities associated with providing these supports
- TruCare Supports has provided me with a copy of their Privacy and Confidentiality Policy.
- TruCare Supports has provided me with a copy of the Record Keeping Policy

Participant Full Name:	**Participant Signature:**	**Date:**
Legal Guardian or Representative Full Name:	**Legal Guardian or Representative Signature:**	**Date:**