



Participant Intake Form

PLEASE ATTACH A COPY OF THE NDIS PLAN WHEN EMAILING THIS FORM

1. Participant Details

Participants' Legal Name			Preferred Name		
DOB		Gender		Pronouns	
Address					
Contact Number					
Email address					
Language spoken at home:	<input type="checkbox"/> English <input type="checkbox"/> Other _____		Interpreter required	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Communication Option/s	<input type="checkbox"/> Email		<input type="checkbox"/> Post	<input type="checkbox"/> Phone	<input type="checkbox"/> SMS
Do you identify as Aboriginal and Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
NDIS Number			NDIS Plan Dates		
Current Plan	<input type="checkbox"/> Existing/Rollover <input type="checkbox"/> New – 1st Plan <input type="checkbox"/> Needing Change of Circumstances				

Is there a Guardianship/Administration/EPOA order in place? Yes No

2. Nominee details: (if applicable)

Name			Primary Carer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Lives with Participant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to participant	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Partner/Spouse <input type="checkbox"/> Other _____				
Residential Address					
Contact Number					
Email address					
Preferred Communication Option/s	<input type="checkbox"/> Email		<input type="checkbox"/> Post	<input type="checkbox"/> Phone	<input type="checkbox"/> SMS



3. Disability / Medical Conditions

1.	4.
2.	5.
3.	6.

4. Goals

What do you want to achieve for yourself? (EG: More social, Regulate my emotions)	
1.	
2.	
Immediately Goal	
In 6 months	

5. Funding Management

- Self-Managed NDIA Managed
 Plan Managed - Please provide details below for sending of BWP invoices

Company Name	
Email	
Is this service provider, meeting your needs and goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Service providers currently using

1. Company Name			
Contact Person			
Phone number			
Email			
Service Provided		Frequency of use	
Is this service provider, meeting your needs and goals?			<input type="checkbox"/> Yes <input type="checkbox"/> No



2. Company Name			
Contact Person			
Phone number			
Email			
Service Provided		Frequency of use	
Is this service provider, meeting your needs and goals?			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Company Name			
Contact Person			
Phone number			
Email			
Service Provided		Frequency of use	
Is this service provider, meeting your needs and goals?			<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Company Name			
Contact Person			
Phone number			
Email			
Service Provided		Frequency of use	
Is this service provider, meeting your needs and goals?			<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Health Care Information
(For emergency purposes only)

Doctor Name	
Phone Number	
Preferred Hospital	



8. Any further information needs to be shared:

9. Declaration & Signature:

I understand that:

These records are owned by Natalie Doreen Clark T/As Blue Wren Pathways:

- Information within these records will be shared with other staff within Blue Wren Pathways, on and only when staff require the information to carry out their duties;
- I can ask to see records and receive a copy;
- Records are archived for a set period according to policy and procedure; and
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: _____

Name: _____ Date: _____

Relationship to participant (Nominee): _____

Signed on behalf of BWP: _____

Name of Staff Member: Natalie Clark

Position of Staff Member: Support Coordinator Date: _____