Participant Intake Form

PARTICIPANT DETAILS		
First Name:	**Last Name:**	
Gender:	**Date of Birth:**	
Address:		
Suburb:	**Postcode:**	**State:**
Contact Number:	**Email address:**	
Preferred method of communication	☐ Phone ☐ SMS ☐ Email ☐ Mail	
NDIS Number:	**NDIS Funding Type:** ☐ Self Managed ☐ Plan Managed ☐ NDIA Managed	
If applicable, Plan Manager/Plan nominee details:		
Name:	**Organisation:**	
Email:	**Contact Number:**	
Plan start date:	**Plan end date:**	

PERSONAL DETAILS	
Aboriginal or Torres Strait Islander descent?	☐ Yes ☐ No

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Living Situation	☐ Own home (living alone) ☐ Own home (living with family) ☐ Living in supported accommodation ☐ Temporary (relatives, friends or other) ☐ At risk ☐ Homeless ☐ Other: _____
Do you have a current Behavioural Support Plan?	☐ Yes ☐ No
Primary Formal Diagnosis:	
Secondary Formal Diagnosis:	
Are there any legal issues that may affect our service? If applicable, please provide details	
Other relevant information:	

REPRESENTATIVE OR EMERGENCY CONTACT DETAILS	
CONTACT 1:	**CONTACT 2:**

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☐ Advocate ☐ Parent ☐ Guardian ☐ Support Person ☐ Emergency Contact ☐ Plan Nominee ☐ Other:	☐ Advocate ☐ Parent ☐ Guardian ☐ Support Person ☐ Emergency Contact ☐ Plan Nominee ☐ Other:
Name:	**Name:**
Relationship to Client:	**Relationship to Client:**
Address:	**Address:**
Contact Number:	**Contact Number:**
Email:	**Email:**
Advocacy Form Supplied?: ☐ Yes ☐ No	**Advocacy Form Supplied?:** ☐ Yes ☐ No

COMMUNICATION	
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other: _____
Languages Spoken	☐ English ☐ Other: _____
Is an Interpreter required?	☐ No ☐ Language ☐ Hearing impaired

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PHYSICAL HEALTH	
☐ Asthma	☐ Diabetes
☐ Epilepsy	☐ Heart Conditions
☐ Visual Impairment	☐ Hearing Impairment
☐ Cognitive Impairment	☐ Blood Disorders
☐ Sleep Apnoea	
☐ Other:	
Medications	**If applicable, please list:**
I would like assistance with managing this by:	

MENTAL HEALTH	
☐ Depression	☐ Anxiety
☐ Post-traumatic stress disorder	☐ Bipolar

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☐ Psychosis	☐ Schizophrenia
☐ Obsessive compulsive disorder	☐ Mood Disorder
☐ Other: _____	

Medications	**If applicable, please list:**
History of hospital admission?	☐ Yes (please provide further details) ☐ No
I would like assistance with managing this by:	

DIETARY REQUIREMENTS		
No dietary requirements	☐ Yes	☐ No
Vegetarian	☐ Yes	☐ No
Vegan	☐ Yes	☐ No
Dairy free	☐ Yes	☐ No

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Gluten free	☐ Yes	☐ No
Allergies	If applicable, please list:	
I do not like to eat: (please list)		
My favorite food is:		

PRACTICAL SUPPORT NEEDS		
I require assistance with:		
Mobility	☐ Independent ☐ Walking Stick ☐ Manual Hoist ☐ Other:	☐ Assist ☐ Walking Frame ☐ Shower Chair
Personal Care	☐ Shower/Bath ☐ Grooming ☐ Other:	☐ Toileting ☐ Dressing
What Busy Home Solutions services do you require?	**In-Home and Community Supports** 1. Assistance in Coordinating or Managing Life Stages, Transitions and Supports 2. Daily personal Activities 3. Assistance with Travel/Transport Arrangements	

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	4. Development of Daily Living and Life Skills 5. Household Tasks 6. Participation in Community, Social and Civic Activities **Supported Independent Living/Respite Care/Group** 1. Assistance with Daily Life Tasks in a Group or Shared Living Arrangement
Busy Home Solutions can assist me by ….	

YOUR PREFERENCES	
Do you have specific preferences when matching our staff with you?:	
Gender	☐ Male ☐ Female ☐ No preference
Age Group	
Culture/Religion/Ethnicity	
Languages spoken	
Personality characteristics	
Specific needs, skills or knowledge required?	

Busy Home PTY SOLUTIONS

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Specific training that may be required to provide services and support to you?	
Is there anything else you would like us to know about you that is important for how we provide our services to you?	
What are your goals, expectations and desired outcomes when receiving our services?	
What are your goals for the next 12 months?	

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CONSENT AND ACKNOWLEDGEMENT

By signing below, I acknowledge that the information provided is true and accurate to the best of my knowledge. I understand that this information will be used for the purpose of assessing my support needs and developing a suitable support plan.

Do you consent to participating in and use of:

☐ Participating in audits of our business by the NDIS Commission and its auditors

☐ Photos for Social Media

☐ None of the above

Signed by the **Client:**

…….. Date: ……./……./……

Signature

……..

Name (please print)

Signed by the **Representative**

…….. Date: ……./……./……

Signature

……..

Name (please print)

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Signed for and on behalf of **Busy Home Solutions ABN 30 676 258 478:**

…….. Date: ……./……./……

Signature

……..

Name (please print)