|  |  |
| --- | --- |
| Participant/ Your Name | Click or tap here to enter text. |
| DOB | Click or tap here to enter text. | Participant/your NDIS no. | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Primary Contact | Click or tap here to enter text. |
| Preferred contact details | Click or tap here to enter text. |

|  |  |
| --- | --- |
| COS Name | Click or tap here to enter text. |
| COS Contact Phone | Click or tap here to enter text. |
| COS Contact Email | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Who do I send your Invoices to? \*Can’t be NDIS Managed | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Diagnosis/Condition | Click or tap here to enter text. |
| Skills/ Training needed. | Click or tap here to enter text. |
| Equipment/ mobility needs (if any) | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Important things to know about Participant/You | Click or tap here to enter text. |
| Things Participant/I like | Click or tap here to enter text. |
| Things Participant/ I do not like | Click or tap here to enter text. |

**What kind of supports are you needing?**

|  |  |  |
| --- | --- | --- |
| NDIS support Item | Please tick | NDIS Goals/ focus of support |
| Assist Self-Care Activity | Yes [ ] No [ ]  | Click or tap here to enter text. |
| Access Community Social and Recreational Activity | Yes [ ] No [ ]  | Click or tap here to enter text. |
| Provider Transport | Yes [ ] No [ ]  | Click or tap here to enter text. |

Preferable days and times:

Click or tap here to enter text.

Please give me an idea of how often you want your supports eg weekly, daily, casually as needed.

Click or tap here to enter text.

Are the above times/ days flexible? Yes [ ]  No [ ]

Ideal start date:Click or tap here to enter text.

Will there be another staff/ family member on shift the first time to do an induction shift with me?

 Yes [ ]  No [ ]  Self [ ]

|  |
| --- |
| Other relevant information: Any pets, other people living with you, Firearms in the home, illegal substance abuse, potential risk or hazards in the home, suicidal thoughts/ tendencies? |
| Click or tap here to enter text. |

|  |  |
| --- | --- |
| Documentation needed for supports | In order to support you with quality care, please provide the below if relevant. |
| Behaviour support Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Risk Assessment | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Communication Profile | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Mealtime Management Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Medication Support Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Epilepsy Support Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Diabetes Management Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Transfer Plan | Yes I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| PEG Management plan | Yes, I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Mental Health Support Plan | Yes, I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |
| Other: Click or tap here to enter text. | Yes, I have one, see attached [ ] No, I do not have one [ ] In process of getting one [ ]  |

Please send through any relevant documentation, so I can ensure I give you/ participant quality care.

Or do you give me permission to contact your COS for relevant documents?

Yes [ ]  No- please note this could mean I can’t support you/ participant [ ]

Should you have any questions or concerns about this form please contact:

Dee Caruana

dee@bloomdisability.com.au M: 0494 086 439