Intake Form
Bloom Thrive Grow

Welcome to Bloom Thrive Grow

Thank you for taking the time to complete this intake form. The more we know about you, the better we can tailor supports to suit your goals, preferences and individual needs. If you're unsure about any questions, simply leave them blank and we can discuss them together.

Participant Information

Participant's Full Name	Click or tap here to enter text.
Preferred Name	Click or tap here to enter text.
Date of Birth	Click or tap here to enter text.
NDIS Number	Click or tap here to enter text.
NDIS Plan Dates	Click or tap here to enter text.
Address	Click or tap here to enter text.

Primary Contact

Primary Contact Name	Click or tap here to enter text.
Relationship to Participant	Click or tap here to enter text.
Phone Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

Preferred Method of Contact

☐ Phone
☐ SMS
☐ Email

Funding Information

How is your NDIS Plan managed?

☐ Self Managed
☐ Plan Managed
☐ NDIA Managed

Who should invoices be sent to?

Click or tap here to enter text.

Support Team

Support Coordinator Name	Click or tap here to enter text.
Organisation	Click or tap here to enter text.
Phone	Click or tap here to enter text.

Email	Click or tap here to enter text.
Recovery Coach (if applicable)	Click or tap here to enter text.
Other Allied Health Professionals	

About the Participant

Diagnosis or Disability (if you would like to share)
Important things you'd like me to know about you
What are your strengths?

What do you enjoy?

- Favourite activities
- Interests
- Hobbies
- Favourite places
- Favourite foods

- Things that make you happy

Things you don't like

Communication

How do you communicate?	Click or tap here to enter text.
Preferred communication style	Click or tap here to enter text.
Communication device used (if applicable)	Click or tap here to enter text.

Interpreter required?

☐ Yes

☐ No

Support Needs

What supports are you looking for?

☐ Assistance with Daily Living

☐ Community Access

☐ Transport

☐ Support Coordination

☐ Recovery Coaching

NDIS Goals / Focus of Supports

Support Worker Requirements

Does your support worker require any specific skills or training?

Examples:

☐Manual Handling

☐Hoist

☐Medication Administration

☐PEG Feeding

☐Epilepsy Management

☐Behaviour Support

☐Mental Health

☐Diabetes Management

☐Suctioning

☐IDDS meals

☐Incontinence care

☐Personal care

☐Other Click or tap here to enter text.

Equipment & Assistive Technology

Please list any equipment used, including:

☐Wheelchair

☐Walker

☐Hoist

☐Shower Chair

☐Communication Device

☐Continence Products

☐Other Click or tap here to enter text.

Availability

Preferred Days & Times:
Click or tap here to enter text.

How often would you like supports?

☐ Daily

☐ Weekly

☐ Fortnightly

☐ Monthly

☐ As Required

Are your preferred days/times flexible?

☐ Yes

☐ No

Preferred Start Date

Click or tap here to enter text.

First Shift

Would you like someone present during your first support?

☐ Family Member

☐ Existing Support Worker

☐ Support Coordinator

☐ No

Personal Preferences

Morning routine
Evening routine
Preferred support worker name: Click or tap here to enter text.
Cultural considerations Click or tap here to enter text.
Religious or spiritual considerations Click or tap here to enter text.
Gender preference for support worker Click or tap here to enter text.

Sensory Preferences

Things that help you feel calm

Sensory triggers
Things to avoid

Behaviour Support

Are there any behaviours of concern?
Known triggers
Early warning signs
Strategies that work well

Health & Safety

Medical conditions
Allergies
Falls risks
Seizure history
Mental health considerations
Other health concerns Click or tap here to enter text.

Home Environment & Risk Assessment

Please let us know about anything that may impact safe service delivery.

Examples include:

☐Pets

☐Smokers

☐Firearms

☐Alcohol or drug use in the home

☐Aggressive behaviours

☐Environmental hazards

☐Other people living in the home

☐Other safety considerations Click or tap here to enter text.

Emergency Information

Emergency Contact Name	Click or tap here to enter text.
Relationship	Click or tap here to enter text.
Phone Number	Click or tap here to enter text.

General Practitioner

Clinic	Click or tap here to enter text.
Phone Number	Click or tap here to enter text.

Preferred Hospital

Click or tap here to enter text.

Supporting Documentation

Please indicate whether you have the following available.

☐NDIS Plan

☐Functional Capacity Assessment

☐Behaviour Support Plan

☐Individual Risk Assessment

☐Communication Profile

☐Mealtime Management Plan

☐Medication Support Plan

☐Epilepsy Management Plan

☐Diabetes Management Plan

☐Transfer Plan

☐PEG Management Plan

☐Mental Health Support Plan

☐Allied Health Reports

☐Hospital Discharge Summary/s

☐Medication Chart

☐Emergency Management Plan

☐Other Click or tap here to enter text.

Consent

May I contact your Support Coordinator or relevant professionals to obtain documents or information required to safely provide supports?

☐ Yes

☐ No

Please note that without relevant information, Bloom Thrive Grow may be unable to safely provide supports.

Declaration

I confirm that the information provided is true and correct to the best of my knowledge.

I understand this information will be used by Bloom Thrive Grow to provide safe, person-centred and individualised supports.

Participant/Representative Name	Click or tap here to enter text.
Relationship to Participant	Click or tap here to enter text.
Signature	
Date	Click or tap here to enter text.