|  |
| --- |
| **Date:** |
| **Participant Details:** |
| Given Name:  |  |
| Surname:  |  |
| Do you have a preferred gender and/or pronoun?  | **[ ]** Male **[ ]** Female **[ ]** Intersex or Indeterminate**[ ]** Do not wish to disclose [ ]  Other – provide details below  |
| Preferred gender:  |
| Preferred pronoun: |
| Are you an Aboriginal or Torres Strait Island descent? [ ] Yes [ ] No  |
| Preferred name: | Date of Birth: |
| **Residential Address Details:** | **Postal Address Details:** |
| Number / Street:  | Number / Street:  |
| State:  | Postcode: | State: | Postcode: |
| **Participant Contact Details:** |
| Email address: |
| Home Phone No: | Mobile No:  |
| **NDIS Information:** |
| NDIS Number:  | Plan review date : |
| NDIS Start Date: | NDIS End Date: |
| **Funding Type:**  |
| [ ]  Self-Managed (If selected fill in the below details) |
| Person invoiced to: |  |
| Relationship to participant:  |  |
| Person invoiced contact number:  |  |
| Person invoiced email:  |  |
| [ ] Plan Managed (If selected fill in the below details) |
| Provider Name:  |  |
| Email Address: |  |
| Contact Number:  |  |
| [ ]  NDIA-Managed [ ]  Combination of any of the above, please select the applicable ones. [ ]  Other (Please fill in the below details)  |
| Institute type: |  |
| Email Address: |  |
| Contact Number: |  |
| **Other NDIS Providers:**  |
| Are you registered with another NDIS provider? [ ]  Yes [ ]  No If yes, please specify the service you are receiving with the NDIS provider:  |
| **Advocate/representative details (if applicable):** |
| Surname: | Given name(s): | Relationship with the participant: |
| Phone No: | Mobile No:  | Email: |
| Address Details:  |
| Postal Address Details: |
| **Other Information:** |  |
| Country of Birth: | Number of years in Australia (if not born in Australia): |
| The main language spoken at home: |
| **Culture, Communication & Intimacy:** |
| Are there any cultural, communication barriers or intimacy issues that need to be considered when delivering services?**[ ]** No  **[ ]** Yes If yes, please indicate below: |
| **[ ]** Verbal communication or spoken language - Is an interpreter needed?  |
| **[ ]** No  |
| **[ ]** Yes | Specify Language:  |
| **[ ]** Cultural values/ beliefs or assumptions: |  |
| **[ ]** Cultural behaviours:  |  |
| **[ ]** Written communication/literacy: |  |
| **Physical Profile** |
| * **Weight: KGs (Kilograms)**
* **Eye Colour: [ ]** Brown **[ ]** Hazel **[ ]** Green **[ ]** Blue
* **What is your build?** **[ ]** Small **[ ]** Medium **[ ]** Large
* **Facial Hair?** **[ ]** Yes **[ ]** No
* **Birth Marks?** **[ ]** Yes **[ ]** No
* **Tattoos?** **[ ]** Yes **[ ]** No
 | * **Height: CMs (centimetres)**
* **What is your complexion?**

**[ ]** Fair **[ ]** Light **[ ]** Olive **[ ]** Dark* **Hair Colour: [ ]** Brown **[ ]** Blonde

**[ ]** Red **[ ]** Black**[ ]** Grey **[ ]** Bold |
| **Emergency Details (Primary Contact)** |
| Contact Name: | Relationship: |
| Home Phone No: | Mobile No: |
| **Emergency Details (Secondary Contact)** |
| Contact Name: | Relationship: |
| Home Phone No: | Mobile No: |
| **GP Medical Contact** |
| Clinic Name: | Email Address:  |
| Surname: | First Name: |
| Address: |
| Telephone Number: | Mobile Phone Number: |
| **Support Coordination Details:**  |
| Contact Name: | Relationship: |
| Phone Number: |
| **Specialist Medical Contact/Behaviour Support Practitioner (if applicable)** |
| Do you see a specialist for a medical condition/disability? **[ ]** No  **[ ]** Yes  |
| Clinic Name: | Email Address: |
| Surname: | First Name: |
| Address:  |
| Telephone Number: | Mobile Phone Number: |
| **Living and support arrangements** |
| What is your current living arrangement? (Please tick the appropriate box)**[ ]** Live with Parent/Family/Support Person**[ ]** Live in private rental arrangement with others **[ ]** Live in private rental arrangement alone**[ ]** Aged Care Facility **[ ]** Owns own home**[ ]** Mental Health Facility **[ ]** Lives in public housing**[ ]** Short Term Crisis/Respite **[ ]** Staff Supported Group Home**[ ]** Hostel/SRS Private Accommodation **[ ]** Other, please specify |
| **Travel** |
| How do you travel to work or to your day service? (Please tick the appropriate box)**[ ]** Taxi **[ ]** Pick up/ drop off by Parent/Family/Support Person**[ ]** Transport provided by a provide **[ ]** Independently use Public Transport **[ ]** Walk **[ ]** Assisted Public Transport **[ ]** Drive own car **[ ]** Other, please specify:  |
| **Disability Conditions/Disability type(s)** |
| Indicate what type of disability or disabilities this participant has including diagnosis eg: ADHD |
| Are there any important people in the Participant’s life such as family member and their relationship?  |

* **Medication Information/Diagnosis/Health Concerns**

|  |  |  |
| --- | --- | --- |
| Does the Participant require a Medication Chart?  | **[ ]** Yes **If yes, is this medication taken on a regular basis and for what purpose, ensure to make mention of this here and complete Form40.Medication Chart and/or Form33. Participant risk assessment**  | **[ ]** No  |
| Does the Participant require Mealtime Management?  | **[ ]** Yes **If yes, refer to Form77. Mealtime Management Plan Form** | **[ ]** No  |
| Does the participant require Bowl Care Management? | **[ ]** Yes **If yes, refer to Form49. Complex Bowel Care Plan and Monitoring Form and indicate what assistance is required with bowel care** | **[ ]** No  |
| Is there any issues with a menstrual cycle or is assistance needed?  | **[ ]** YesIf yes, please specify:  | **[ ]** No  |
| Does the Participant require female hygiene assistance?  | **[ ]** Yes  | **[ ]** No  |
| Does the Participant have Epilepsy? | **[ ]** Yes **If yes, ensure Participant’s Doctor completes an Epilepsy Plan** | **[ ]** No  |
| Is the Participant an Asthmatic?  | **[ ]** Yes **If yes, ensure Participant’s Doctor completes an Asthma Plan** | **[ ]** No  |
| Does the Participant have any allergies?  | **[ ]** Yes**If yes, ensure to have an Allergy Plan from Participant’s Doctor**  | **[ ]** No  |
| Is the Participant anaphylactic?  | **[ ]** Yes **If yes, ensure to have an anaphylaxis Plan from the Participant’s Doctor** | **[ ]** No  |
| Do you give permission for our company’s staff to administer band-aids in cases of a minor injury? | **[ ]** Yes  | **[ ]** No  |
| Does this participant require specific training?  | **[ ]** Yes **If yes, ensure to provide information such as implementing a positive behaviour support plan**  | **[ ]** No  |
| Are there any other medication conditions that will be relevant to the care provided to this Participant?  | **[ ]** Yes **If yes, please specify** | **[ ]** No  |
| IS there any specific trigger for community activities? | **[ ]** Yes **If yes, please specify and complete the Risk assessment for participants in Form27.Initial Assessment and Support Plan** | **[ ]** No  |

* **Safety Considerations**

|  |  |  |
| --- | --- | --- |
| Does the Participant show signs or a history of unexpectedly leaving (absconding)? | **[ ]** Yes **If yes, please specify** | **[ ]** No  |
| Does the Participant show any signs or a history of respiratory depression? | **[ ]** Yes **If yes, please specify the type of medication that was prescribed.** | **[ ]** No  |
| Is this participant prone to falls or have a history of falls?  | **[ ]** Yes  | **[ ]** No  |
| Is there any behaviours of concern? Eg: kicking, biting.  | **[ ]** Yes **If yes, please specify** | **[ ]** No  |
| Is there a current Positive Behaviour Support Plan (PBS) in place?  | **[ ]** Yes **If yes, refer to Form56.High Risk Participant Register.** | **[ ]** No  |
| Does the participant require communication assistance?  | **[ ]** Yes **If yes, refer to the mode of communication reflected in Form33. Participant Risk Assessment and disaster management plan** | **[ ]** No  |
| Is there any physical assistance or physical assistance preference for this Participant?  | **[ ]** Yes **If yes, specify**  | **[ ]** No  |
| Does the Participant have any expressive language concerns? | **[ ]** Yes **If yes, Form33. Participant Risk Assessment and disaster management plan under OH&S Assessments and Mode of Communication.** | **[ ]** No  |
| Does this Participant have any personal preferences & personal goals? | **[ ]** Yes **If yes, refer to form Form27.Initial Assessment and Support Plan** | **[ ]** No  |

* **OHS & risk assessments.**

Refer to Form33. Participant Risk Assessment and Disaster Management Plan

Signature of participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

[If signed by a Nominee:]

I confirm that this agreement has been explained to the person receiving the services (participant) and that they agree to this:

Signature of Nominee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Signature on behalf of **Amazing Help Pty Ltd**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_