|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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? | Yes  If 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: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_