**PARTICIPANT INTAKE FORM**

1. **Participant Details**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Name |  | | D.O.B | / / | | Gender | |  |
| Contact details | Home |  | Mobile |  | | | | |
| Email address |  | | | | | | | |
| Language spoken at home: |  | | Interpreter required | | | | ❒ Yes ❒ No | |
| Preferred option for communication | ❒ Email ❒ Post ❒ Phone | | | | Do you identify as Aboriginal and Torres Strait Islander?  ❒ Yes ❒ No | | | |
| Residential Address: |  | | | | | | | |
| Postal Address  (if different from above) |  | | | | | | | |

Is there a Guardianship and/or Administration order in place? ❒ Yes ❒ No

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Parent/Guardian 1 |  | | | Primary Carer | | ❒ Yes | ❒ No |
| Lives with Participant | | ❒ Yes | ❒ No |
| Emergency Contact | | ❒ Yes | ❒ No |
| Relationship to participant | ❒ Parent ❒ Guardian ❒ Caregiver ❒ Other | | | | | | |
| Residential Address: |  | | | | | | |
| Postal Address  (if different from above) |  | | | | | | |
| Contact details | Home |  | Mobile | |  | | |
| Email address |  | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Parent/Guardian 2 |  | | | Primary Carer | | ❒ Yes | ❒ No |
| Lives with Participant | | ❒ Yes | ❒ No |
| Emergency Contact | | ❒ Yes | ❒ No |
| Relationship to participant | ❒ Parent ❒ Guardian ❒ Caregiver ❒ Other | | | | | | |
| Residential Address: |  | | | | | | |
| Postal Address  (if different from above) |  | | | | | | |
| Contact details | Home |  | Mobile | |  | | |
| Email address |  | | | | | | |

1. **Disability / Medical Conditions including any diagnosis if relevant.**

|  |
| --- |
| 1. |
|  |
|  |
| 2. |
|  |
|  |
| 3. |
|  |
|  |

**Other service providers currently using**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use: |  |

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use: |  |

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use: |  |

1. **Health Care Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Medicare Number |  | Expiry Date: |  |
| Reference Number: |  |
| Private Healthcare Provider |  | Membership Number |  |
| Reference Number |  |

|  |  |
| --- | --- |
| Doctor Name |  |
| Address |  |
| Phone Number |  |

1. **Funding**

❒ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIA managed participants)

|  |  |
| --- | --- |
| NDIS Number: |  |
| NDIS Date: |  |

❒ Self-Managed ❒ Plan Managed

Please provide details for invoices

|  |  |
| --- | --- |
| Name |  |
| Email |  |
| Comments |  |

1. **Preferences**

|  |  |
| --- | --- |
| Preferred name |  |
| Religious Requirements |  |
| Cultural Requirements |  |
| Communication device |  |
| Physical Assistance |  |
| Other Considerations |  |

1. **Goals and Aspirations**

|  |  |
| --- | --- |
| What do you want to achieve for yourself – life skills, physically, socially etc? | |
|  | |
| Immediately |  |
| In 6 months |  |
| Next year |  |

I understand that:

* These records are owned by this organisation.
* Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties
* I can ask to see records and receive a copy
* Records are archived for a set period according to policy and procedure
* I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_