# **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 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 |  |

 **2. 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: |  |

## 3. Health Care Information

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

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

## 4. 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 |  |

## 5. Preferences

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

## 6. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_