## Participant Details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Participant Name** |  | | D.O.B | / / | Gender | |  |
| **NDIS Number** |  | | | | | | |
| **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

Is there a Behaviour Management Plan in place? ❒ Yes ❒ No

Participants under the age of 18, 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** |  | | | | | | |

## Disability / Medical Conditions including any diagnosis if relevant.

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

**Medication/s Required**

|  |  |  |
| --- | --- | --- |
| **Medication Assessment Tool** | **Strategies Developed** | **Identified in Support Plan** |
| Medication Plan and Consent Form | Yes  No | Yes  No |
| Medication – Self Medication Assessment | Yes  No | Yes  No |
| Medication Risk Indemnity Form | Yes  No | Yes  No |

**Behaviour Support**

Behaviour Support Plan documents collected for authorisation purposes ❒ Yes ❒ No

(if relevant)

Behaviour Support Plan available on NDIS portal? ❒ Yes ❒ No

**Other service providers currently using (include Specialist Behaviour Support Provider, if relevant)**

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

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

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

## Health Care Information

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

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

## 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** |  |

## Preferences

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

## Goals and Aspirations

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

1. **Risk Assessment**

|  |  |  |
| --- | --- | --- |
| **Risk Assessment Tool** | **Strategies Developed** | **Identified in Support Plan** |
| Individual Risk Assessment Profile | Yes  No | Yes  No |
| Safety Environment Checklist – Home | Yes  No | Yes  No |
| Participant Safe Environment Risk Assessment | Yes  No | Yes  No |
| Nutrition and Swallowing Risk Checklist | Yes  No | Yes  No |

I understand that:

* This organisation owns these records.
* 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:

|  |  |
| --- | --- |
| **Participant Signature or** |  |
| **Parent / caregiver signature** |
| **Name of the person signing** |  |
| **Relationship to the participant, if not the participant** |  |
| **Date** |  |

Note: Authority to Act as an Advocate form is required if the individual signing this form is not the participant.