## 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.