Participant Intake Form

1. 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				

2. 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 (if relevant) ❒ Yes ❒ No

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:	

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	

7. 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.