PARTICIPANT INTAKE FORM

Please return this form to [yasscare.au@gmail.com](mailto:yasscare.au@gmail.com)

## Referral Type

|  |  |  |
| --- | --- | --- |
| Referral Type: | ☐ Seeking Support Worker | ☐Seeking Support Coordination |

# Section 1: Client Information

## Client Details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: |  | | | | | | |
| Diagnosis: |  | | | | | | |
| Date of Birth: |  | | Sex:☐Male ☐Female ☐Other | | | | |
| Nationality: |  | | Indigenous status: ☐Yes ☐No | | | | |
| Address: |  | | | | | Post Code: |  |
| Home Phone: |  | | Mobile: | | | | |
| Email: |  | | | | | | |
| Living Arrangement: | | ☐With Parents | | ☐Private Rental | | | |
| ☐Aged/Nursing Home | | ☐Supported Accommodation | | ☐Other (Please specify:) | | | |
| Preferred Language: | | | | | Interpreter Required: ☐Yes☐No | | |

## Next of Kin /Guardian Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Full Name: |  | | | |
| Relationship: |  | Email: |  | |
| Address: |  | | | Post Code: |
| Home Phone: |  | Mobile: |  | |

## NDIS Plan Information

|  |
| --- |
| NDIS Fund Management:☐Self-Managed ☐NDIS Managed ☐Plan Managed |
| NDIS Reference Number: |
| NDIS Service Plan Dates: Start Date: dd/mm/yyyy Review Date: dd/mm/yyyy |
| **PLEASE ATTACH THE NDIS PLAN TO THIS FORM** |

## Payment/Invoicing Details

|  |  |  |  |
| --- | --- | --- | --- |
| Portal Service Bookings required?☐Yes☐No | | | |
| If No, invoicing/Plan Manager details are as follows: | | | |
| Organisation: |  | Phone: |  |
| Email: |  | Fax: |  |

## Support Co-Ordinator Details

|  |  |  |  |
| --- | --- | --- | --- |
| Coordinator Name: |  | Organisation: |  |
| Contact Number: |  | Email: |  |
| Address: |  | | |

# Section 2: Client Health Information

## Disability and Health

|  |  |
| --- | --- |
| Primary Disability: |  |
| Secondary Disability: |  |
| Other Health Alerts: |  |
| Medical Condition: |  |
| Allergies: |  |
| Does the client have regular medications? ☐Yes ☐No | |
| Is the client able to self-medicate? ☐Yes ☐No  ***If the answer was No, please attach a list of all medications they require assistance with.*** | |

## Personal care

|  |  |
| --- | --- |
| Requires support with toileting: ☐Yes ☐No | Able to self-dress and groom:☐Yes ☐No |
| Requires support with showering/bathing:  ☐Yes ☐No | ☐Other (please specify:) |

## Communication

|  |
| --- |
| The client is: ☐Fully Verbal ☐Non-Verbal ☐Other |
| Comments or other considerations: |

## Mobility

|  |
| --- |
| The client is: ☐Independent ☐Non-Ambulant ☐Requires some supervision |
| Other Mobility Considerations: |

**About the Participant**

|  |  |
| --- | --- |
| About Me: |  |
| Likes: |  |
| Dislikes: |  |

## Goals

|  |  |
| --- | --- |
| Short-term: |  |
| Medium-term: |  |
| Long-term: |  |

# Behavioural Information

|  |
| --- |
| Are there behaviours of concern? ☐Yes ☐No |
| If yes, please provide a brief description, or a behavioural management plan: |

# Section 4: Support Requirements

Please select when support is required.

|  |  |  |  |
| --- | --- | --- | --- |
|  | AM | PM | Timings/Comments/Tasks |
| **Monday** | ☐ | ☐ |  |
| **Tuesday** | ☐ | ☐ |  |
| **Wednesday** | ☐ | ☐ |  |
| **Thursday** | ☐ | ☐ |  |
| **Friday** | ☐ | ☐ |  |
| **Saturday** | ☐ | ☐ |  |
| **Sunday** | ☐ | ☐ |  |
| **NDIS: Hours Approved: Total Cost:** | | | |
| **NDIS Support Category:** | | | |
| Staff Gender Preference: ☐Male ☐Female ☐No Preference | | | |

# Section 5: Further Information

|  |
| --- |
| Please list any other information or any circumstances that we need to be aware of: |
|  |