Complete Choice
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23 Kent Road Macdonald Park SA 5121

# 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** | | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| **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. |
| |

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** | |

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| | |
|---|---|
| **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

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| | |
|---|---|
| **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 profile | ☐ Yes ☐ No | ☐ Yes ☒ No |
| Safety Environment Checklist – Home | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | |

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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.