Participant Intake Form

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1.Participant Details

Name:	D.O.B:	Gender:
Preferred name:	Cultural background:	
Address:		
Postal Address (if different from above):		
Mobile:	Phone:	Email:
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		
NDIS Funding type:	☐ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIS managed participants) ☐ Self-Managed ☐ Plan Managed	
NDIS Number:	NDIS start date: NDIS end date:	
Invoicing details	Name: Preferred option for communication: Phone number: Email: Address:	

2.Representative Details

Name of Representative:		
Lives with Participant	☐ Yes	☐ No
Relationship to participant: ☐ Parent ☐ Guardian ☐ Caregiver ☐ Other (please specify):		
Address:		

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Phone:	
Email:	
Preferred method of contact:	

3.Emergency Contact Details

Is emergency contact the same as above? ☐ Yes ☐ No		
Name of emergency contact:		
Lives with Participant	☐ Yes	☐ No
Relationship to participant: ☐ Parent ☐ Guardian ☐ Caregiver ☐ Other (please specify):		
Address:		
Phone:		
Email:		
Preferred method of contact:		

4.Health Care Information

Medicare Number:	Expiry Date: Reference Number:
Private Healthcare Provider:	Membership number: Reference Number:

5.About the Participant

Living situation	☐ Living alone in my own home ☐ Living with my family ☐ Supported Accommodation ☐ Temporary ☐ Other:
Types of disability	
Religious/ cultural requirements	

Does the participant need physical assistance equipment or support	
Does the participant need assistive devices for communication	
Is the participant visually impaired	
Does the participant have any dietary requirements	
Does the participant have any swallowing difficulties	
Other considerations	
Does the participant have a current behavioural support plan?	☐ Yes ☐ No
IF yes, please provide the details of your behaviour practitioner	Practitioner's name: Contact number: Address:
Medical condition/diagnosis	
Medical condition/diagnosis	
Medical condition/diagnosis	
Allergies	
Please provide details of your medical practitioner	Name: Contact number: Address:

6.Name of other current service providers

1	Name	
	Address	
	Phone number/email	
	Emergency contact	
	Frequency of use	
	Type of service	

2	Name	
	Address	
	Phone number/email	
	Emergency contact	
	Frequency of use	
	Type of service	
3	Name	
	Address	
	Phone number/email	
	Emergency contact	
	Frequency of use	
	Type of service	
4	Name	
	Address	
	Phone number/email	
	Emergency contact	
	Frequency of use	
	Type of service	

7.Goals

What do you want to achieve for yourself – life skills, physically, socially etc?	
Short term goals	
Long term goals	

8.Consent

Please sign below to show that you agree with the information in this client intake form

Intake form was completed by	
Participant Signature	
Parent / caregiver signature	
Name of the person signing	
Relationship to the participant, if not the participant	

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Date	