

**PARTICIPANT INTAKE FORM**

CARE MODE INTAKE FORM

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| PARTICIPANT DETAILS  |
| First Name: Surname: Date of Birth: Female [ ]  Male [ ]   Contact Number:Email Address: Cultural Background: Interpreter required: Yes: [ ]  No: [ ] Primary Contact: Participant [ ]  Next of Kin [ ]  Other: [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| NDIS PLAN DETAILS |  |
| NDIS SUPPORTS: Self-managed: [ ]  Plan - managed: [ ]  NDIA managed plan: [ ]  NDIS Reference Number:  NDIS Service Plan Dates: Start Date / / End Date / / |  |
| NEXT OF KIN DETAILS  |  |
| Name:  Contact Number:Email Address:  Relationship to Participant: |
| **INFORMATION ABOUT ME** |
| About the Participant summary:**Likes and dislikes of the participant:** |

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| Any Behaviours of Concern?Medical History:**NDIS: Hours approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Services requested: |
| PREFERRED DAYS / HOURS OF SERVICE |
| DAYS TIMES OF SUPPORTS Monday: [ ]  Tuesday: [ ]  Wednesday: [ ]  Thursday: [ ]  Friday: [ ]  Saturday: [ ] Sunday: [ ]  Any: [ ]   |
| SUPPORT CO-ORDINATOR DETAILS |
| Coordinator Name: Organisation: Name:  Contact Number:Address:Email Address:   |
| REFERRER DETAILS: |
| Referrer Name: Organisation: Name:  Contact Number:Address:Email Address:  Relationship to Participant: |
| **INVOICING DETAILS** |
| **Portal Service bookings required -** Yes: [ ]  No: [ ] **If no, invoicing / Plan Manager details as follows:**Contact: Organisation:Phone: Fax:Email:  |
| DETAILS OF EXISTING TEAM TO SEND FEEDBACK TO |
| Name:  | Service: | Contact details: phone, email, fax |
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 PLEASE ATTACH THE NDIS PLAN ON THE THIS FORM