

**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