|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
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| Participant Details | | | | | | |
| Participant Name |  | | D.O.B |  | Gender |  |
| 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

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Parent/Guardian** |  | | | 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** |  | | | | | | |

|  |
| --- |
| Disability / Medical Conditions Including Any Diagnosis If Relevant |
| 1. |
| 2. |
| 3. |

|  |
| --- |
| Participant health issues and how to escalate urgent health situation |
| 1. |
| 2. |
| 3. |

|  |  |  |  |
| --- | --- | --- | --- |
| Other Service Providers Currently Using | | | |
|  | Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use |  |
|  | Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use |  |
|  | Name |  |
| Address |  |
| Phone number/email |  |
| Frequency of use |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Care Information | | | | | |
| **Medicare Number** | | |  | **Expiry Date** |  |
| **Reference Number** |  |
| **Private Healthcare Provider** | | |  | **Membership Number** |  |
| **Reference Number** |  |
| **Doctor Name** | | |  | | |
| **Address** | | |  | | |
| **Phone Number** | | |  | | |
| **Funding** | | | | | |
| ❒ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIS managed participants) | | | | | |
| NDIS Number | |  | | | |
| NDIS Date | |  | | | |
| ❒ Self-Managed ❒ Plan Managed | | | | | |
| Please provide details for invoices | | | | | |
| Name |  | | | | |
| Email |  | | | | |
| Comments |  | | | | |
| **Preferences** | | | | | |
| Preferred name |  | | | | |
| Religious Requirements |  | | | | |
| Cultural Requirements |  | | | | |
| Communication device |  | | | | |
| Physical Assistance |  | | | | |
| Other Considerations |  | | | | |

|  |  |
| --- | --- |
| Goals and Aspirations | |
| What do you want to achieve for yourself – life skills, physically, socially etc? | |
| Immediately |  |
| In 6 months |  |
| Next year |  |

I understand that:

* These records are owned by this organization.
* Information within these records will be shared with other staff within the organization 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:

Signature of Participant or Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_