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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** |  |

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

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

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| --- |
| 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 |  |

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| 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  |  |

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| --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_