Date:			
Participant Details (required)			
Surname:	Given name(s):	Sex: ☐ Male ☐ Female ☐ Intersex or Indeterminate ☐ Prefer not to say	
Are you an Aboriginal or Torres Strait Island descent? ☐ Yes ☐ No			
Preferred name:		Date of Birth:	
Residential Address Details (required)		**Postal Address Details (required)**	
Number / Street:		Number / Street:	
State:	Postcode:	State:	Postcode:
Participant Contact Details (required)			
Email address:			
Home Phone No:		Mobile No:	
NDIS Information (required)			
NDIS Number:		Plan review date (Must be reviewed annually):	
NDIS Start Date:		NDIS End Date:	
Funding type: ☐ Plan managed ☐ Self-managed ☐ NDIA managed ☐ Other If plan managed provide their details below Provider name: Email address: Contact Number: Send invoices to:			
Are you registered with another NDIS provider? ☐ Yes ☐ No If yes, please specify the service you are receiving with the NDIS provider:			
Advocate/representative details (if applicable)			
Surname:	Given name(s):	Relationship with the participant:	
Phone No:	Mobile No:	Email:	
Address Details:			
Postal Address Details:			
Other Information			

Country of Birth:	Number of years in Australia (if not born in Australia):
The main language spoken at home:	Is a language interpreter required? ☐ Yes ☐ No

Are there any cultural, communication barriers or intimacy issues that need to be considered when delivering services?

☐ No ☐ Yes If yes, please indicate below:

☐ Verbal communication or spoken language - Is an interpreter needed? ☐ No ☐ Yes Language: .....

☐ Cultural values/ beliefs or assumptions: .....

☐ Cultural behaviours: .....

☐ Written communication/literacy: .....

Physical Profile

- **Weight:**
- **Eye Colour:** ☐ Brown ☐ Hazel ☐ Green ☐ Blue
- **What is your build?** ☐ Small ☐ Medium ☐ Large
- **Facial Hair?** ☐ Yes ☐ No
- **Birth Marks?** ☐ Yes ☐ No
- **Tattoos?** ☐ Yes ☐ No

- **Height:**
- **What is your complexion?** ☐ Fair ☐ Light ☐ Olive ☐ Dark
- **Hair Colour:** ☐ Brown ☐ Blonde ☐ Red ☐ Black ☐ Grey ☐ Bold

Emergency Details (Primary Contact) (required)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:
Emergency Details (Secondary Contact)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:
GP Medical Contact (if applicable)	
Clinic Name:	Email Address:
Surname:	First Name:
Address:	
Telephone Number:	Mobile Phone Number:
Support Coordination Details (if applicable)	
Contact Name:	Relationship:
Email:	Mobile Phone No.
Specialist Medical Contact/Behaviour Support Practitioner (if applicable)	

Do you see a specialist for a medical condition/disability?	☐	No	☐	Yes	
Clinic Name:	Email Address:				
Surname:	First Name:				
Address:					
Telephone Number:	Mobile Phone Number:				

Living and support arrangements (required)

What is your current living arrangement? (Please tick the appropriate box)

☐	Live with Parent/Family/Support Person	☐	Aged Care Facility	☐	Owns own home
☐	Live in private rental arrangement with others	☐	Hostel/SRS Private Accommodation		
☐	Live in private rental arrangement alone	☐	Lives in public housing		
☐	Mental Health Facility	☐	Staff Supported Group Home		
☐	Short Term Crisis/Respite	☐	Other, please specify:		

Travel (required)

How do you travel to work or school or to your day service? (Please tick the appropriate box)

☐	Taxi	☐	Pick up/ drop off by Parent/Family/Support Person
☐	Transport provided by a provide	☐	Independently use Public Transport
☐	Walk	☐	Assisted Public Transport
☐	Drive own car	☐	Other, please specify:

Disability Conditions/Disability type(s)

Indicate what type of disability or disabilities this participant has including diagnosis eg: ADHD

Are there any important people in the Participant's life such as family member and their relationship?

Educational Placement *(if applicable and attach relevant reports)*

Does the participant currently attend school or kindergarten?	☐	No	☐	Yes

If yes, name of the school / kindergarten / work / education site?								
If yes, does the participant receive support within their environment?				☐	No	☐	Yes	
If yes, which type? *(thick all that applies)*	☐	ESL	☐	NEP/IEP		☐	Gowrie	
	☐	Education Support Worker	☐	Speech		☐	Special Education	
	☐	1!1 SSO	☐	Class SSO		☐	OT	
	☐	Other						
Teacher's Name			Class/Year/Level					
Main concerns within this setting *(thick all that applies)*	☐	Communicating	☐	Playing with other kids		☐	Completing work	
	☐	Sharing with other kids	☐	Challenging Behaviours		☐	Transition	
	☐	Disruptive behaviours	☐	Engaging in group activities				
	☐	Other						

Examples of what these concerns look like for the participant in these settings:

Services required

Which of the following services best applies to your requirements? *(tick all that applies)*

☐ Household task	☐ Therapeutic Support
☐ Early childhood support	☐ Community Participation
☐ Development – life skills	☐ Assistance – travel/transport
☐ Group/centre activities	☐ Assistance – personal activities
☐ Innovative Community Participation	☐ Assistance – High intensity personal activities
☐ Daily Tasks / Shared Living	☐ Behaviour Support

☐ Other support:

Availability for behaviour support services *(this gives us an idea when scheduling therapy hours)*

Sessions (2h – 3h per session)	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Morning 08:30 am to 11:30am					

Lunch 12:00 noon to 02:30pm					
Afternoon 03:30pm to 05:30pm					

PLAY AND LEISURE ACTIVITIES
Participant's likes and interests
What does the participant play with / enjoy doing / how does the participant entertain themselves? For how long?

Behaviour of concern ***(if applicable)***			
Does the participant engage in any behaviours of concern? If yes, please elaborate. If no, please skip to the next section.			
Answers to the next questions relate to each other. Please respond as per their respective columns.			
	1	**2**	**3**
Top 3 most concerning behaviours			
When are they most likely to happen			
Describe if they occur around any specific activities			

What triggers the behaviour			
How do you and others react / respond to it to stop it?			
How do you / others calm / distract the participant once they are engaging in it?			
Name 3 of the participant's strengths?			

➢ **Medication Information/Diagnosis/Health Concerns** ***(if applicable)***

Does the Participant require a Medication Chart?	☐ Yes **If yes, is this medication taken on a regular basis and for what purpose, ensure to make mention of this here and complete Form 40. Medication Chart and/or Form 33. Participant risk assessment**	☐ No
Does the Participant require Mealtime Management?	☐ Yes **If yes, refer to Form 77. Mealtime Management Plan Form**	☐ No
Does the participant require Bowel Care Management?	☐ Yes **If yes, refer to Form 49. Complex Bowel Care Plan and Monitoring Form and indicate what assistance is required with bowel care**	☐ No
Is there any issues with a menstrual cycle or is assistance needed?	☐ Yes If yes, please specify:	☐ No
Does the Participant require female hygiene assistance?	☐ Yes	☐ No

Does the Participant have Epilepsy?	☐ Yes **If yes, ensure Participant's Doctor completes an Epilepsy Plan**	☐ No
Is the Participant an Asthmatic?	☐ Yes **If yes, ensure Participant's Doctor completes an Asthma Plan**	☐ No
Does the Participant have any allergies?	☐ Yes **If yes, ensure to have an Allergy Plan from Participant's Doctor**	☐ No
Is the Participant anaphylactic?	☐ Yes **If yes, ensure to have an anaphylaxis Plan from the Participant's Doctor**	☐ No
Do you give permission for our company's staff to administer band-aids in cases of a minor injury?	☐ Yes	☐ No
Does this participant require specific training?	☐ Yes **If yes, ensure to provide information such as implementing a positive behaviour support plan**	☐ No

Are there any other medication conditions that will be relevant to the care provided to this Participant?	☐ Yes **If yes, please specify**	☐ No
IS there any specific trigger for community activities?	☐ Yes **If yes, please specify and complete the Risk assessment for participants in Form 27. Initial Assessment and Support Plan**	☐ No

➢ **Safety Considerations**

Does the Participant show signs or a history of unexpectedly leaving (absconding)?	☐ Yes **If yes, please specify**	☐ No
Does the Participant show any signs or a history of respiratory depression?	☐ Yes **If yes, please specify the type of medication that was prescribed.**	☐ No
Is this participant prone to falls or have a history of falls?	☐ Yes	☐ No
Is there any behaviours of concern? Eg: kicking, biting.	☐ Yes **If yes, please specify**	☐ No
Is there a current Positive Behavior Support Plan (PBS) in place?	☐ Yes **If yes, refer to Form 56. High Risk**	☐ No

	Participant Register.	
Does the participant require communication assistance?	☐ Yes **If yes, refer to the mode of communication reflected in Form 33. Participant Risk Assessment and disaster management plan**	☐ No
Is there any physical assistance or physical assistance preference for this Participant?	☐ Yes **If yes, specify**	☐ No
Does the Participant have any expressive language concerns?	☐ Yes **If yes, Form 33. Participant Risk Assessment and disaster management plan under OH&S Assessments and Mode of Communication.**	☐ No
Does this Participant have any personal preferences & personal goals?	☐ Yes **If yes, refer to Form 27. Initial Assessment and Support Plan**	☐ No

- **OHS & risk assessments**

Refer to Form 33. Participant Risk Assessment and Disaster Management Plan

Signature of participant: _____ Date: _____/_____/_____

[If signed by a Nominee:]
I confirm that this agreement has been explained to the person receiving the services (participant) and that they agree to this:

Signature of Participant: _____Date: _____/_____/_____

Signature on behalf of **[Organisation Name]**: _____ Date: _____/_____/_____