**NEW CLIENT PARTICIPANT INTAKE FORM**

Here at Adala Care we are committed to providing services to you in a way that respects your cultural, diverse values and beliefs and communicate with you in a mode, language, terms and in communication you understand

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name |  | | | | |
| Last Name |  | | | | |
| Date of Birth |  | Email |  | | |
| Phone Number |  | | | | |
| Address |  | | | | |
| City |  | State |  | Postcode |  |
| Funding Body |  | NDIS Number | |  | |
| NDIS Plan Dates | Start Date |  | | End Date |  |
| Occupation |  | | | | |
| Gender | ☐Female ☐Male ☐Transgender ☐Rather not say ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pronouns (if applicable): | | | | |
| Housing Type | ☐ Own home ☐ Private Rental: ☐ Supported Accommodation: ☐ Nursing Home ☐ Other: | | | | |

**Is the Client (Tick All That Apply)**

* Male
* Female
* Aboriginal
* Torres Strait Islander
* Aboriginal & Torres Strait Islander

**Does the Client need an interpreter?** ☐ No ☐ Yes

If Yes, language required?

|  |  |
| --- | --- |
| What Disability Or Medical Diagnosis Is Present? |  |
| Any Allergies? |  |

**Referred By**

* NDIS
* Mission Australia
* Friend/ Family
* Self-Referred

**PRIMARY CONTACT DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name |  | | | | |
| Last Name |  | | | | |
| Email |  | | | | |
| Phone Number |  | | | | |
| Address |  | | | | |
| City |  | State |  | Postcode |  |
| Relationship to Participant |  | | | | |

**Does The Participant Have A Carer?**

* Yes
* No

**Carer & Other Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  | Phone |  |
| Emergency Contact |  | Phone |  |

**How Are Supports Managed / Funded?**

* Participant is Plan Managed
* Participant is Self-Managed
* Participant is NDIA Managed
* Other

**NDIS Plan Period**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NDIS Reference Number |  | | | |
| NDIS Plan Start Date |  | NDIS Plan End Date | |  |
| Funding Not To Exceed |  | Service Agreement Total | |  |
| Plan Manager Name |  | | Plan Manager Phone |  |
| Plan Manager Email |  | | | |

**Preferred Methods Of Invoice Receipt**

* Post Mail
* Email

**Core Budget Total**

|  |
| --- |
|  |

**Copy of NDIS Plan**

* Yes
* No

**Intensity of Supports**

* Standard
* Complex
* Intense

Are Expenses Included In Supports?

* Yes
* No

*\*Kilometers billed @ $1.00 Per Kilometer When Travelling Further Than 10KM*

**Does the participant require a car seat to be transported?**

* Yes
* No

**Summary Of Services Requested/ To Be Provided**

*For Example Assistance With Activities Of Daily Living, Support Coordination*

* Accommodation/Tenancy
* Outreach
* Day Trip
* Retreat/ Short Term Accommodation
* Assist Access/Maintain Employ
* Assist-Life Stage, Transition
* Assist-Personal Activities
* Assist-Travel/Transport
* Community Nursing Care
* Daily Tasks/Shared Living
* Innovative Community Participation
* Development-Life Skills
* Household Tasks
* Participate Community
* Support Coordination
* Group/Centre Activities

*Other (Specify):*

|  |
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|  |

**Duration/Hours Requested:**

|  |
| --- |
|  |

**Details Of Support Requirements**

*For example, bowel care needs, medication assistance, PEG feeds*

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Does The Participant Have Any Cultural, Diverse, Speciﬁc Values or Beliefs That They Would Like To Inform PFCC About Or Have Supports Centered Around?

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|  |

*We aim to sensitively respond to your needs in all aspects of service delivery. Staﬀ are trained in cultural competence and will respect your needs appropriately.*

|  |  |
| --- | --- |
| Service Start Date |  |
| Service End Date |  |
| Preferred days of service delivery: | |
| ☐ Monday ☐Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Any | |

|  |  |
| --- | --- |
| **Referrer Details:** | |
| Name | Organization |
| Office Phone: | Mobile |
| Email: | Address |

|  |  |
| --- | --- |
| **Support Coordinator Details: (if different from the referrer:)** | |
| Name | Organization |
| Office Phone: | Mobile |
| Email: | Address |

|  |  |
| --- | --- |
| **Plan Manager Details:** | |
| Name | Organization |
| Office Phone: | Mobile |
| Email: | Address |

**Are Supports**

* Flexible In Times Or Days?
* To Be Provided On Public Holidays

**Support Worker Preference**

* Male
* Female

**Any Geographical Requirements/ Access Codes/ Key Codes?**

**I Currently Experience The Following**

* Stress
* Frequent Headaches
* Pregnancy
* Arthritis
* Diabetes
* Blood Pressure Issues
* Taking Medication For Blood Pressure Issues
* Epilepsy
* Seizures
* Joint Swelling
* Varicose Veins
* Osteoporosis
* Allergies
* I Have A Contagious Disease
* Tension or Soreness In Speciﬁc Areas
* Cardiac Issues
* Circulatory Issues
* Stabbing Pain
* Numbness
* I Have Recently Had Surgery
* Other Medical Condition Or Issue

I Take The Following Medications & Understand That I Will Need An Authority From My Treating Practitioner For Assistance With Medication Administration:

|  |
| --- |
|  |

Details Of Any Health Professionals You Regularly See

|  |
| --- |
|  |

If you have answered yes to any of these questions please provide further details around health care management, recommended actions and any relevant reports from your doctor- i.e stress management plans, bowel care management plan etc

If you have answered yes to any of the above questions, do you want us to assist you with any management of health issues/concerns? If so, how would you like us to support you?

|  |
| --- |
|  |

**Is a behaviour management plan in place?**

* Yes
* No

**Does the participant require a behaviour management plan?**

* Yes
* No

**Are There any behaviours of concern present? Describe Types**

|  |
| --- |
|  |

**Types of Disability**

|  |
| --- |
|  |

**Is the participant taking or prescribed medication for behaviours of concern (Not related to managing a mental health condition such as schizophrenia) If so, name medication**

|  |
| --- |
|  |

**Are there any complex medical needs present? (Describe) How will complex medical needs be managed?**

|  |
| --- |
|  |

**Are there any support plans present or required to be implemented to manage condition?**

* Yes
* No

|  |  |  |  |
| --- | --- | --- | --- |
| Checklist Completed By |  | | |
| Name of Participant or Guardian |  | | |
| Signature of Participant or Guardian |  | Date |  |

|  |
| --- |
| **Office use only:**  Referral Form ☐ Authorised ☐ Not Authorised  Authorised by: Signature:  Comments: |

|  |
| --- |
| ☐ PCP, Medication Form and Consent Forms sent by the Client Services Department  Communicated by: ☐ Email ☐ Phone ☐ Post to:    Staff Name: Date:  **or**  ☐ Communication made to say we cannot provide services  Communicated by: ☐ Email ☐ Phone ☐ Post to:    Staff Name: Date: |

|  |
| --- |
| Followed up and reviewed by:  Client Services Manager: Signature: Date: |

|  |
| --- |
| Additional Comments: |