**Inspire Inclusion Intake Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Participant Details | | | | | | |
| Name: |  | | | | D.O.B |  |
| Address: |  | | | | | |
| Aboriginal or Torres Straight Islander: | | | |  | | |
| Contact details | | | | | | |
| Ph: |  | | | | Mobile |  |
| Email |  | | | | | |
| Preferred contact person: | |  | | | | |
| Legal Guardian/Person Responsible: | | | |  | | |
| Contact Details for participant | | | | | | |
| Name: |  | | | | | |
| Address: |  | | | | | |
| Relationship to participant: | | |  | | | |
| Phone |  | | | | Mobile |  |
| E: |  | | | | | |

|  |  |  |
| --- | --- | --- |
| **Diagnosis:** | | |
|  | | |
| **Secondary disability and other health conditions:** | | |
|  | | |
| **Allergies:** | | |
|  | | |
| **Medications:** | | |
| **Name:** | **Dosage:** | **Reason for taking:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Living Skills** | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Areas** | **Independent** | **With Support** | **With Full Support** | | **Personal Care** |  |  |  | | **Domestic** **Tasks** |  |  |  | | **Meal Preparation** |  |  |  | | **Budgeting/Finances** |  |  |  | | **Shopping** |  |  |  | | **Access to the Community** |  |  |  |       **Health Contacts** | | |
| |  |  |  | | --- | --- | --- | | **Name** | **Address** | **Phone Number** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | |
| **Physiotherapy:** | | |
| Does the participant have any mobility concerns? If so, please describe support needs. | | |
| **Occupational Therapy:** | | |
| Does the participant have equipment needs? If so, please describe needs. | | |
| **Speech Pathology:** | | |
| Does the participant have communication difficulties in either expressive and receptive skills?    If so, does the participant have a communication plan?      Does the participant have swallowing issues?      If so, do they have a mealtime management plan? | | |
| **Behaviour Support:** | | |
| Does the participant have behaviours that we need to be aware of, if so please describe?      Is a behavioural practitioner involved with the participant? Who is the practitioner? | | |
| **Support Coordinator**  Does the participant have a Support Coordinator?          **Other Services:** | | |
| Are there other services involved with the participant such as Communities and Justice? If so, please provide contact details and any other relevant details. | | |
|  | | |
| **Participant’s disability support network** | | |
| **Supports and Service Provider** | | |
| Support | Service Provider | Contact |
| Behaviour |  |  |
| Speech Pathology |  |  |
| Occupational Therapy |  |  |
| Psychology |  |  |
| Support Coordination |  |  |
|  | | |
| |  |  |  |  | | --- | --- | --- | --- | | NDIS Payment and Billings | | | | | NDIS No |  | Plan Dates |  | | Is your plan Self-Managed or Plan Managed? | |  | | | Plan Manager: |  | | | | Ph: |  | Email: |  | | Permission to contact them to verify funds for proposed services? | |  | |   **NDIS Goals** | | |
| Goals Participant wishes to achieve with this NDIS plan: | | |
|  | | |
|  | | |
| Thank you so much for taking the time to complete our intake form.  We will be in contact with you shortly!  Kristy Battle  Service Provider  Ph: 0411 731 370  E: enquiries@inspireinclusion.com.au | | |

