**Inspire Inclusion Intake Form**

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| 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: |  |

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| **Diagnosis:**    |
|      |
| **Secondary disability and other health conditions:**  |
|      |
| **Allergies:** |
|     |
| **Medications:** |
| **Name:**   | **Dosage:**   | **Reason for taking:**   |
|    |    |    |
|   |   |   |
|   |   |   |
|   |   |   |
|    |    |    |
| **Living Skills**   |
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| --- | --- | --- | --- |
| **Areas**  | **Independent**  | **With Support**  | **With Full Support**  |
| **Personal Care**   |   |   |   |
| **Domestic** **Tasks** |   |   |   |
| **Meal Preparation** |  |  |  |
| **Budgeting/Finances** |   |   |   |
| **Shopping**   |   |   |   |
| **Access to the Community**   |   |   |   |

  **Health Contacts**   |
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| --- | --- | --- |
| **Name**  | **Address**  | **Phone Number**  |
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| **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   |      |    |
|    |
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| 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 BattleService ProviderPh: 0411 731 370E: enquiries@inspireinclusion.com.au |

