	# Form20.Participant Intake Form	
Doc No: Form20	**Version No: 01**	**Version Date: 15/01/2020**

Date:			
Personal Details			
Surname:	Given name(s):		Sex : ☐ Male ☐ Female ☐ Intersex or Indeterminate
Preferred name:			Date of Birth:
Residential Address Details		**Postal Address Details**	
Number / Street:		Number / Street:	
State:	Postcode:	State:	Postcode:
Contact Details			
Email address:			
Home Phone No:		Mobile No:	
NDIS Information			
NDIS Number:		Plan review date(Must be reviewed annually):	
NDIS Start Date:		NDIS End Date:	
Funding : ☐ Plan managed ☐ Self-managed ☐ NDIA managed ☐ other --------------			
Are you registered with another NDIS provider? ☐ Yes ☐ No If Yes, please Specify the service you are receiving with the NDIS provider:			
Diagnosis or Health Concerns			
Advocate / Representative Details (If applicable)			
Surname:	Given name(s):	Relationship with 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):
Main language spoken at home:	Is a language Interpreter required? ☐ Yes ☐ No
Are there any cultural or communication barriers that need to be considered when delivering services? ☐ No ☐ 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)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:
Emergency Details (Secondary Contact)	
Contact Name:	Relationship:
Home Phone No:	Mobile No:
GP Medical Contact	
Clinic Name:	Email Address:
Surname:	First Name:
Address:	
Telephone Number:	Mobile Phone Number:
Specialist Medical Contact	
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

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

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

Travel

How do you travel to work 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:

Signature		Date	