

NDIS Participant Intake Form

Participants Information		Date:	
Participant's Name			
Address of Participant			
Post Code		Gender	
Participant's Date of Birth		Age	
Monash Health UR number (if known)			
Participant's contact details	Home:	Mobile:	
Preferred contact method			
Preferred contact person			
Name of person registering client for NDIS services. <i>(Please confirm if person registering client for services is able to sign on participant's behalf and if yes, request signed documentation)</i>	Relationship to participant:		
	Contact details:		
Participants Plan Nominee contact details or contact person.	Relationship to participant:		
	Contact details		
Does the participant give consent for our service to contact the plan nominee?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Country of Birth		Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Preferred language?	
Participant's primary disability?			
Other medical conditions (if any)			
Do you identify as Aboriginal or Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there any cultural considerations that we need to know about? (please specify)	No		
Participant's occupation			

Does the participant have a MyGov account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Participant access a Centrelink benefit? If so, what benefit?	Choose an item.
NDIS Details	
Participant's NDIS Number	
NDIS Plan dates	
Can you please send through a copy of the participants NDIS plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Therapy/Support Coordination, is the Participant's Plan self-managed, NDIA or Plan Managed?	Choose an item. Contact details (if applicable)
The dollar amount allocated within the NDIS plan for Support Coordination/Therapy Services	
Has the participants NDIS portal been set up	<input type="checkbox"/> Yes <input type="checkbox"/> No
Referral Information	
What NDIS funded service/s are you requesting through Monash Health?	
Reason for referral	
Current services being received by the participant <i>eg. OT, Physio. Speech therapist, AOD (Alcohol and or Other Drug), Other – please specify</i>	
Contact details of organisations providing current services to participant	
Is there any issues that we need to know that might result in risk to staff or the participant? (e.g Any special family circumstances or legal orders in place, behaviours of concern, drug and alcohol issues)	
Contact details and signature of worker completing this form	<u>Name:</u> <u>Position:</u> <u>Contact details:</u> Signature of worker Date: