Monash Health

Reset Form

NDIS Participant Intake Form

Phone: 9792 7716

Email: MBX_NDISsupport_Coordination@monashhealth.org

UR:
Patient Name:
DOB:
Sex:
Address:

Mobile:
Email:

NDIS PARTICIPANT INTAKE FORM (Page 1 of 4)

Participant's Information		**Date:**	
Has the participant / nominee consented to this referral?	Yes ☐ No ☐		
Participant's Full Name			
Address of Participant			
Participant's contact details	**Home Phone:**		
	Mobile Phone:		
	Email address:		
Participant's preferred pronoun	She ☐ He ☐ They ☐	Gender	Female ☐ Male ☐ Prefer not to say ☐
Participant's Date of Birth		Age	
Country of birth		Interpreter required	Yes ☐ No ☐
Does the participant identify as being Aboriginal/Torres Strait Islander?	Yes ☐ No ☐	Preferred language?	
Are there any cultural/religious considerations that we need to know about?	Yes ☐ No ☐ Please specify if 'yes':		
Preferred contact person	**Name:**		
	Relationship to the participant:		
	Contact details *(If different from above):* **Address:** **Phone:** **Email:**		
	Is the contact person the Plan Nominee? Yes ☐ No ☐		
	Preferred contact method: Phone ☐ Email ☐		

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Name of person referring (if different to contact person)	**Relationship to participant:**
	Contact details:
Participant's Plan Nominee contact details or contact person (if different to contact person)	**Relationship to participant:**
	Contact details:
Who will sign the Service Agreement?	Participant: ☐ Plan Nominee: ☐ Other ☐ Name:
Participant's primary disability (if any)	
Other Medical Conditions (if any)	
GP Details	**Name:**
	Address:
	Phone:
	Email:

NDIS Details

Participant's NDIS Number	
NDIS Plan dates	**Start date**: **End date:**
Does the participant/plan nominee consent to share their NDIS plan with our service?	☐ Yes Please send copy plan when returning this form ☐ No Please list plan goals below or send part copy of plan when returning this form

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Referral Information

What NDIS funded service/s are you requesting through Monash Health?	☐ Support Coordination ☐ NDIS Adult Program ☐ Continence ☐ NDIS Children's Program
If requesting services with Adult or Children's program please select which ones.	☐ Feeding Clinic (Children only) Comments: ☐ Speech Pathology ☐ Occupational Therapy ☐ Physiotherapy (Children only) ☐ Dietetics
Current services being received by the participant *e.g. Allied Health, Support Coordinator, Support Workers)*	**Service(s):** **Contact details:**
Preferred location of service provision/delivery	**Monash Health sites** ☐ Springvale ☐ Pakenham ☐ Cranbourne ☐ Kingston Centre (Continence only) ☐ Dandenong (Continence only) **Other Locations** ☐ Child Care Centre ☐ Kindergarten ☐ School ☐ Participant's Home/Shared living accommodation – *a maximum of 30 minutes travel each way can be accommodated*

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Is there any issues that we need to know that will assist us in working with the participant? *(e.g. Any special family circumstances or legal orders in place, e.g.: VCAT, Intervention Orders, behaviours of concern, drug and alcohol issues)*	

Billing Information

How is the participant's NDIS funding managed?	Self ☐ Plan Managed ☐ NDIA ☐
Plan Manager details (if plan managed)	**Name:**
	Organisation:
	Address:
	Phone Number:
	Email:
What is the allocated funding amount in the participant's NDIS Plan for the service that is being requested?	Support Coordination Capacity Building Amount: ☐ Adult or Children's Program Capacity Building Amount: ☐ Continence Capacity Building Amount: ☐ Core Amount:

Referrer Name:		Designation:		Date:
Service/Ward Name:		Contact Number		

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