|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Participant Details:** | | | | | |
| **Name:** |  | | | | |
| **NDIS number:** |  | | | | |
| **Plan Dates:** |  | | | | |
| **DOB:** |  | | **Gender:** |  | |
| **Address:** |  | | **State:** |  | |
| **Email Address:** |  | | **Phone:** |  | |
| **Preferred Contact Person:** |  | | | | |
| 1. **Preferred contact may include plan nominee/family member or other:** | | | | |
| **Name:** | |  | | |
| **Relationship to participant:** | |  | | |
| **Address:** | |  | | |
| **Contact phone number:** | |  | | |
| **Email Address:** | |  | | |
| **Special Considerations:** | |  | | |

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| --- | --- | --- | --- |
| 1. **Provider Representative Details:** | | | |
| **Service provider name:** |  | | |
| **Contact name:** |  | | |
| **Qualification:** |  | | |
| **Address:** |  | **State:** |  |
| **Email Address:** |  | **Phone:** |  |

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| --- | --- | --- | --- |
| 1. **Alerts and Allergies**   **Please provide precise/ detailed information:** | | | |
| **Allergies or Allergic to** | **Warning Signs & Symptoms** | **Immediate Action Required** | |
|  |  |  | |
|  |  |  | |
|  |  |  | |
| 1. **Participant’s Goals** | | |
| **Goal 1.**  **Goal 2.**  **Goal 3.**  **Goal 4.**  **Goal 5.**  **Goal 6.** | | |

1. **CURRENT SERVICES & SUPPORT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CURRENT SERVICES & SUPPORT** | | | | | **UPCOMING SERVICES & SUPPORT** | | |
| **Social & Community Participation** | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
| **Day Program/Group** | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
| **Accommodation** | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
| **Respite**  **(Short term Accommodation)** | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
| **Holiday** | No of Days | Times | Staff Needed | Provider | No. of Days | Times | Staff Needed |
| **In Home Support**  Personal Care  Cleaning  Shopping  Yard Maintenance  Household Tasks  Meal Preparation  Medication Assist | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
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|  |  |  |  |  |  |  |
| **Transport** | Kms To | Kms From | Kilometres Total | Provider | Kms To | Kms From | Kilometres Total |
| **Therapy** | Frequency | **COMMENTS** | | Provider | Frequency | **COMMENTS** | |
| Speech Therapy |  |  | |  |  |  | |
| Behavioural Therapy |  |  | |  |  |  | |
| Occupational Therapy |  |  | |  |  |  | |
| Physiotherapy |  |  | |  |  |  | |
| Physical/ Exercise |  |  | |  |  |  | |
| Dietician |  |  | |  |  |  | |
| Other |  |  | |  |  |  | |
| **Aids & Equipment** | Type | Age of equipment | Repairs or maintenance needed | Provider | Type | COMMENTS | |
| **Incontinence Aids** | Type | No. Per Day | | Provider | Type | No. Per Day | |
| **Home Mods including SDA**  **(Specialists Disability Accommodation)** | COMMENTS | | | Provider | COMMENTS | | |
| **Support Coordination Level** | COMMENTS | | | Provider | COMMENTS | | |
| **Supported Employment**  **DMI LEVEL:** | Days of Week | Times | Staff Needed | Provider | Days of Week | Times | Staff Needed |
| **NDIS Plan Management** (Please Circle) | | | | | | | |
| **Plan Managed**    **NDIS Managed**    **Self-Managed** | | | | Provider | COMMENTS | | |

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| Personal Hygiene | Grooming | Money | Money Handling | Personal Safety | Road Safety | Relationships | Friendships |
| Social Interaction | Consequences | Sexuality | Literally | Numeracy | Time | Self | Problem Solving |
| Behaviour | Emotions/Feelings | Sensory Processing | Communication | Writing | Employment | Fine Motor Skills | Gross Motor Skills |
| Choices | Decision Making | Independence |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

1. **Capacity Building Areas**

|  |  |  |  |
| --- | --- | --- | --- |
| **DAILY ASSISTANCE** | **ASSISTANCE COMMUNICATION** | **BEHAVIOURS OF CONCERN** | **EVIDENCE REPORTS SUPPLIED** |
| VERBAL PROMPT | NON-VERBAL | ABSCONDING | SCHOOL |
| AIDS/EQUIPMENT | VISUAL/PHYSICAL AIDS | SELF HARM | GP |
| STAND-BY ASSITANCE | GESTURES | WITHDRAWAL | SPECIALISTS |
| FULL ASSISTANCE | VERBAL | AGGRESSION | ALLIED HEALTH |
| OTHER | OTHER | SEXUAL | MENTAL HEALTH |
|  |  | OTHER | SERVICE PROVIDERS |
|  |  |  | HOSPITAL |
|  |  |  | COMMUNITY HEALTH |
|  |  |  | OTHER |

1. **Support Needs Information**

**Additional Comments**

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