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| **About the NDIS Participant** | | | | | | | | | | | | | |
| NDIS Number | |  | | | | Request Date | | | |  | | | |
| First Name | |  | | | | Middle Name | | | |  | | | |
| Surname | |  | | | | Preferred Name | | | |  | | | |
| Phone Number | |  | | | | Mobile Number | | | |  | | | |
| Email Address | |  | | | | Date of Birth | | | |  | | | |
| Address | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Disability Type** | | | ☐ Psychosocial  ☐ Autism | | ☐ Intellectual  ☐ Physical | | | | | ☐ Mental Health  ☐ Other - Specify | | | |
| **Secondary Condition** | | | ☐ Psychosocial  ☐ Autism | | ☐ Intellectual  ☐ Physical | | | | | ☐ Mental Health  ☐ Other - Specify | | | |
| **Do you have a BSP?** | | | | | ☐ Yes | | | ☐ No | | Details: | | | |
| **Do you have any restrictive practices?** | | | | | ☐ Yes | | | ☐ No | | Details: | | | |
| **Do you require medication administration?** | | | | | ☐ Yes | | | ☐ No | | Details: | | | |
| **Preferred Worker** | | | | | ☐ Male | | | ☐ Female | | ☐ No Preference | | | |
| **Indigenous Status** | | | | | ☐ Aboriginal | | | | ☐ Torres Strait Islander | | ☐ Both | | ☐ Neither |
| **Preferred Contact Method** | | | | | ☐ Phone | | | | ☐ Face to Face | | ☐ Email | | ☐ SMS |
| **Interpreter Required** | | | | | ☐ Yes | | | | ☐ No | | ☐ Preferred Language | | |
|  | | | | | | | | | | | | | |
| **Participant’s Nominee Contact (Next of Kin)** | | | | | | | | | | | | | |
| First Name |  | | | | | | Last Name | | | | |  | |
| Address |  | | | | | | | | | | | | |
| Relation |  | | | | | | Phone Number | | | | |  | |
| Email |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **About the NDIS Plan** | | | | | | | | | | | | | |
| Start Date | | | |  | | | End Date | | | | |  | |
| Plan Included: | | | | ☐ Yes | | | ☐ No (Please specify goals if not plan provided | | | | | | |
| Billing Details: | | | | ☐ NDIA | | | ☐ Plan Managed | | | | | ☐ Self-Managed | |
| Plan Manager Details (Organisation, Name, Contact Number, Email) | | | |  | | | | | | | | | |
| Support Coordinator Details (Organisation, Name, Contact, Email) | | | |  | | | | | | | | | |
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| **NDIS Support Item** | | | | | | | | | | | | | |
| **NDIS Support Item Number** | **Days/Support Dates** | | | **Time of Supports** | | | | | **Transport Required?** | | | | **Are these times/days flexible?** |
|  |  | | |  | | | | |  | | | |  |
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| **Interests/Hobbies** | | | | | | | | | | | | | |
| ☐ Music  ☐ Volunteering  ☐ Craft  ☐ Movies  ☐ Socialising | | ☐ Eating Out  ☐ Sport  ☐ Gardening  ☐ Building/Wood Working  ☐ Fashion/shopping | | | | | ☐ Card Games  ☐ Gym  ☐ Cooking  ☐ Video Games  ☐ Other | | | | | ☐ Art  ☐ Dancing  ☐ Cleaning  ☐ Cars  ☐ Other | |
|  | | | | | | | | | | | | | |
| **My Supports** | | | | | | | | | | | | | |
| Do you have allergies | | | | | ☐ Yes | | | ☐ No | | | Please provide Anaphylaxis Action Plan. | | |
| Do you have a tracheostomy? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have a catheter? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have any complex wounds? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have a PEG tube? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you require complex bowel care? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have epilepsy/seizures? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have diabetes? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you have asthma? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you give permission for SASS staff to apply sunscreen? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
| Do you give permission for SASS staff to insect repellent? | | | | | ☐ Yes | | | ☐ No | | | Details | | |
|  | | | | | | | | | | | | | |
| **Dietary Requirements** | | | | | | | | | | | | | |
| ☐ Vegetarian  ☐ Vegan | | | ☐ Kosher  ☐ Halal | | | | | | | ☐ Gluten Free  ☐ Non | | | |
|  | | |  | | | | | | |  | | | |
| **Medical Emergency** | | | | | | | | | | | | | |
| In an emergency SASS will engage with emergency services without parental or nominee permission. | | | **Date:** | | | | | | | **Sign:** | | | |
|  | | | | | | | | | | | | | |
| **Consent for Photographs/Video Recording** | | | | | | | | | | | | | |
| ☐ Social Media  ☐ Reports | | ☐ Newspaper  ☐ Personal File | | | | ☐ Media/TV  ☐ SASS Website | | | | | | | |
|  | | | | | | | | | | | | | |
| **Support Needs** | | | | | | | | | | | | | |
| ☐ Personal Care | | ☐ Toileting | | | | ☐ Medication Administration | | | | | | ☐ Mobility/Transferring | |
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| **Tell Us About You** | | | | | |
| Strengths |  | | | | |
| Interests/Hobbies |  | | | | |
| Challenges |  | | | | |
| Likes/Dislikes |  | | | | |
| Triggers |  | | | | |
| Behaviours |  | | | | |
| Additional Comments |  | | | | |
|  | | | | | |
| **Who is Completing this Request for Services** | | | | | |
| **Agency Name** |  | | | | |
| **Contact Person** |  | | **Phone:** |  | |
| **Email:** |  | | **Mobile:** |  | |
|  | | | | | |
| **Where did you hear about SASS?** | | | | | |
| ☐ Website  ☐ Social Media  ☐ Friends or Family  ☐ Other (Please Specify) | | | | | |
|  | | | | | |
| **Registering Officer (Office Use Only)** | | | | | |
| **Name:** | | **Date:** | | | **Signature:** |