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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:** |