**PARTICIPANT INTAKE FORM**

**PERSONAL INFORMATION**

|  |
| --- |
| Full Name: |
| Date of Birth: | **Identifies As:** |
| Home Phone: | **Mobile Number:** |
| Address: |
| Email Address: |
| Cultural Background: | **Interpreter Required? ○** Yes ○ No |
| Preferred Contact Method: |

|  |
| --- |
| Name Primary Contact: |
| Phone Number: | **Email Address:** |
| Address: |
| Support Coordinator: | **Phone Number:****Email Address:** |

**NDIS**

|  |  |
| --- | --- |
| NDIS Number: | Plan Dates: |
| Please Tick: ○ Plan Managed ○ Self-Managed ○ NDIA Managed |
| Contact of Plan Manager if Applicable: |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Risk Factors / Alert Issues

|  |  |
| --- | --- |
| ○ Epilepsy? | ○ Epilepsy Management Plan? |
| ○ Diabetes? | ○ Diabetes Management Plan? |
| ○ PBSP? | ○ Copy of PBSP? |
| ○ Mealtime Management Required | ○ Mealtime Management Plan |
| ○ Medication Management Required | ○ Medication Management Plan |

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**DETAILS FOR APPOINTMENTS**

|  |
| --- |
| Reason for Referral: |
| Contact of Plan Manager if Appliable: |
| Day/Time Preferences:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday |
| Morning |  |  |  |  |
| Afternoon |  |  |  |  |
| Evening |  |  |  |  |

 |

**OTHER INFORMATION**

|  |
| --- |
| Presenting Disabilities/Care Needs: |
| Likes: | **Dislikes:** |
| Participants’ Culture, Diversity, Values and Beliefs: |
| Other Relevant Preferences/Needs: |
| Emergency Response Requirements |

**PARTICIPANT / GUARDIAN DECLARATION**

*I consent to my information being provided to Elevated Psychology and Supports for the purposes of referral, service delivery and inclusion in de-identified data reporting.*

Name:

Date:

Signature: