DLS ALLIED HEALTH

NDIS Participant Intake Form

Purpose: To allow us to find the most suitable practitioner to provide services to the participant.

Participant Details	
Full Name:	Preferred Name:
Pronouns:	D.O.B:
Address:	Preferred Contact Method: Phone ☐ Email ☐
Email:	Phone:
Preferred Language(s):	Gender:
NDIS Number:	Is the participant verbal? Yes ☐ No ☐
Interpreter Required? Yes ☐ No ☐	
Living Arrangement: Alone ☐ Family/Partner ☐ Other:	
Does the participant identify as Aboriginal or Torres Strait Islander? Yes ☐* No ☐ **If yes, please specify:*	
Does the participant identify as Culturally and Linguistically Diverse (CALD)? Yes ☐* No ☐ **If yes, please specify:*	
Referrer Details	
Referrer Organisation Name (if applicable):	
Job Title/Role: Family/Guardian/Advocate ☐ Support Coordinator ☐ Case Manager ☐ LAC ☐	
Referrer Name:	Referrer Contact Number:
Referrer Email Address:	
Primary, Alternative or Emergency Contact	
Contact Name:	Preferred Contact Method: Phone ☐ Email ☐
Relationship to Participant:	Contact Number:
Email:	
Address (optional):	
Guardian or Advocate	
Guardian Name:	Contact Number:
Email:	
Address (optional):	
Guardianship/Advocate Provisions: Health ☐ Accommodation ☐ Other:	

Disability or Diagnosis
Please include information about the participants disability or diagnosis, including if there are more than one disability or diagnosis and any other conditions.

Referral Details
Please include any relevant information about participants reason for referral, this may include relevant NDIS goals. The sections below provide tick boxes to highlight the services required for the participant.

Services Selection	
Occupational Therapy	Ongoing Therapy ☐ Assessment ☐ If assessment, please provide information on the assessments required: Please provide the number of funded hours:
Speech Pathology	Ongoing Therapy ☐ Assessment ☐ If assessment, please provide information on the assessments required: Please provide the number of funded hours:
Physiotherapy	*DLS Allied Health does not currently offer Physiotherapy services.*
Positive Behaviour Support	*DLS Allied Health does not currently offer PBS services.*
Allied Health Assistant (Therapy Assistant)	Yes ☐ No ☐ If required, please include details of which discipline/therapy you would like a Therapy Assistant to provide.

Safety and Health/Care Requirements
Does the participant have a Positive Behaviour Support plan in place? Yes ☐ No ☐ *If yes, please attach a copy to this document.*
Does the participant have a history of suicidal ideation (within the last 30 days)? Yes ☐ No ☐
Does the participant have a history of falls in the last 6 months? Yes ☐ No ☐ If yes, please provide details:
Does the participant experience difficulties with pressure care? Yes ☐ No ☐ If yes, please provide details:
Does the participant experience difficulties with swallowing/drinking? Yes ☐ No ☐ If yes, please provide details:
Is the participant engaged with external providers and health care providers for other services/support? Yes ☐ No ☐ If yes, please provide details: *For example, this may include support workers, employment providers, doctor (GP), youth mental health etc.*
Home Visit Risk Self-Assessment *DLS Allied Health can provide services at an alternate location (subject to availability) if services are not appropriate or safe to be delivered within the participant's home/property.*
Is anyone at the participants property known to be aggressive? Yes ☐ No ☐ If yes, please provide details:
Is anyone at the participants property have a criminal history? Yes ☐ No ☐ If yes, please provide details:
Is there a history of drugs or alcohol misuse at the property? Yes ☐ No ☐ If yes, please provide details:
Are you aware of any weapons being stored at the property? Yes ☐ No ☐ If yes, please provide details:
Are there any pets at the property? Yes ☐ No ☐ If yes, please provide details:
Are there any details to help allow access to the property? Yes ☐ No ☐ If yes, please provide details: *For example, street sign not visible, shared driveway, limited parking, gate difficulties, which door should be used, are there uneven or dangerous paths.*
Are there any other risk factors we should be aware of? Yes ☐ No ☐ If yes, please provide details:

Funding/Payment and NDIS Plan Details
NDIS Plan Start Date:
NDIS Plan End Date:
How is the participants NDIS funding managed? Plan-Managed ☐ Self-Managed ☐
Plan management organisation name (if applicable):
Email Address (to receive invoices for services):
Phone Number (to contact regarding invoices):

Please provide any additional information that would help us match the best practitioner to the participant, or if there was not adequate space for information in the form.