PLAY GROW FLOURISH PTY LTD

NDIS Support services

ABN 30 655 994 282

0414258314

playgrowflourish@hotmail.com

Client Intake form - About Me and My Supports

Client Details

Full Name:			Title		
Gender:	☐ Female ☐ Male ☐ Non-Binary ☐ Other (please Specify) _____				
Address:			Postcode:		
Plan Start Date		Plan End Date		State:	
NDIS Number:			DOB:		
Mobile:		Phone:			
Email:					
Preferred Contact Method:	☐ Phone ☐ Text ☐ Email ☐ Letter ☐ Other				

Self Management / Plan Manager Details:

Name:		Company:	
Phone:		Email:	
Preferred Contact Method:	☐ Phone ☐ Text ☐ Letter ☐ Email ☐ Other		

Alternate Contact Next of Kin/ Plan Nominee

Name:		Relationship:	
Phone:		Email:	

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Advocate Information (where required) / Formal Decision Maker (where required):

Name:		Relationship:	
Phone:		Email:	

Primary and Secondary Disability

My Communication and Language

My Preferred Language:

I require an interpreter ☐ Yes ☐ No

I require assistance to communicate ☐ Yes ☐ No

Details:

Where assistance is required with communication, please complete a communication plan

My Cultural and spiritual beliefs:

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People who are important to me:

My Living Arrangements (who I live with in what type of setting)

My Likes and interests

My Dislikes

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My Supports

My Ideal Staff member would be (e.g., male/female, age, interests):

Do you have an Emergency or Disaster Management Plan with another provider?

☐ **No** – refer to my safety assessment.
☐ **Yes**-
  ☐ I provide consent to speak to the provider (see consent form)
  ☐ I do not provide consent to speak to the provider

If there was an emergency or disaster, how would you like us to support you?

☐ Creation of Emergency Management Plan
☐ Other provide details:

What is important to me in the support I receive from Play Grow Flourish?

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Medical History and Requirements

The Date I last (include relevant assessments):

Visted a doctor _____

Had a full health assessment _____

Visited a dentist: _____

Had a vision test: _____

Updated my vaccinations _____

Had a medication review _____

Falls risk review _____

Other _____

My Health Concerns (where applicable)

Do you require Personal Protective Equipment (PPE) to be supplied during service delivery?

Any allergies (including medications, dressing, etc.)?

☐ No

☐ Yes – What are the allergies and do you have an emergency management plan to support the adverse reaction

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Mealtime Management

I have specific dietary requirements or require support to eat my food.
(e.g., seating position, textured foods)

☐ **Yes**
Please provide your Mealtime Management Plan developed by a Health Practitioner

☐ **No**

Where preparing meals or offering mealtime management please complete the below section

Foods I like to eat: _____

_____

Drinks I like: _____

_____

Foods and Drinks I do not like _____

_____

Food allergies _____

_____

_____

Dietary Requirements _____

_____

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My Support Schedule

My typical day looks like

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING							
AFTERNOON							
EVENING							

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I have a Behaviour Support Plan

☐ **No**
☐ **Yes**
☐ **I require a plan to be developed**

I require assistance with my medication

☐ **No**
☐ **Yes**
please provide a medication schedule from your prescribing practitioner that is dated no longer than three months old.

Notes Other information I would like to share?

OFFICE USE ONLY

Plans or Forms Required
☐ My Communication Plan
☐ Emergency Management Plan
☐ Medication Administration Consent Form
☐ Mealtime management plan
☐ Medication Health Record from GP or Pharmacist
☐ Behaviour Support Plan
☐ Other forms, please specify (e.g., asthma plan)

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