



Form20.Participant Intake Form

Doc No: Form20

Version No: 01

Version Date: 18/12/2025

Date					
Participant Details:					
Given Name:					
Surname:					
Do you have a preferred gender and/or pronoun?	☐ Male ☐ Female ☐ Intersex or Indeterminate				
	☐ Do not wish to disclose ☐ Other – provide details below				
	Preferred gender:				
	Preferred pronoun:				
Are you an Aboriginal or Torres Strait Island descent?				☐ Yes ☐ No	
Preferred Name				Date of Birth	
Residential Address Details:			Postal Address Details:		
Number / Street:			Number / Street:		
State:		Postcode:	State:		Postcode:
Participant Contact Details:					
Email address					
Home Phone No		Mobile No			
NDIS Information:					
NDIS Number:		Plan review date (Must be reviewed annually):			
NDIS Start Date:		NDIS End Date:			
Funding Type:					
☐ Self-Managed (If selected fill in the below details)					
Person invoiced to:					
Relationship to participant:					
Person invoiced contact number:					
Person invoiced email:					



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☐ Plan Managed (If selected fill in the below details)

Provider Name:

Email Address:

Contact Number:

☐ NDIA-Managed

☐ Combination of any of the above, please select the applicable ones.

☐ Other (Please fill in the below details)

Institute type:

Email Address:

Contact Number:

Other NDIS Providers:

Are you registered with another NDIS provider? ☐ Yes ☐ No

If yes, please specify the service you are receiving with the NDIS provider:

Advocate/representative details (if applicable):

Surname

Given
name(s)

Relationship with the participant:

Phone No

Mobile No

Email:

Address Details

Postal Address
Details

Other Information:

Country of Birth:

Number of years in Australia (if not born in Australia):

The main language spoken at home:

Transition Planning Support

Are you expecting any upcoming transitions in your life that may need planning and support?
(For example: moving between services, moving to a new home, changing support providers)

☐ No

☐ Yes If yes, Please complete Form23. Transition Plan

Culture, Communication & Intimacy:

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Are there any cultural, communication barriers or intimacy issues that need to be considered when delivering services? ☐ No ☐ Yes If yes, please indicate below:

☐ Verbal communication or spoken language - Is an interpreter needed?

☐ No

☐ Yes

Specify Language:

☐ Cultural values/ beliefs or assumptions:

☐ Cultural behaviours:

☐ Written communication/literacy:

Physical Profile

- **Weight: 49 KGs**
(Kilograms)
- **Eye Colour:** ☐ Brown ☐ Hazel ☐ Green ☐ Blue
- **What is your build?** ☐ Small ☐ Medium ☐ Large
- **Facial Hair?** ☐ Yes ☐ No
- **Birth Marks?** ☐ Yes ☐ No
- **Tattoos?** ☐ Yes ☐ No

- **Height: 160 CMs**
(centimetres)
- **What is your complexion?**
☐ Fair ☐ Light
☐ Olive ☐ Dark
- **Hair Colour:**
☐ Brown ☐ Blonde
☐ Red ☐ Black
☐ Grey ☐ Bold

Emergency Details (Primary Contact) Mother

Contact Name:

Relationship:

Home Phone No:

Mobile No:

Emergency Details (Secondary Contact)

Contact Name:

Relationship:

Home Phone No:

Mobile No:

GP Medical Contact

Clinic Name:

Email Address:

Surname:

First Name:

Address:

Telephone Number:

Mobile Phone Number:

Support Coordination Details:



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Contact Name:

Relationship:

Phone Number:

Specialist Medical Contact/Behaviour Support Practitioner (if applicable)

Do you see a specialist for a medical condition/disability? ☐ No ☐ Yes

Clinic Name:

Email Address:

Surname:

First Name:

Address:

Telephone Number:

Mobile Phone Number:

Living and support arrangements

What is your current living arrangement? (Please tick the appropriate box)

- | | |
|---|---|
| ☐ Live with Parent/Family/Support Person | |
| ☐ Live in private rental arrangement with others | |
| ☐ Live in private rental arrangement alone | |
| ☐ Aged Care Facility | ☐ Owns own home |
| ☐ Mental Health Facility | ☐ Lives in public housing |
| ☐ Short Term Crisis/Respite | ☐ Staff Supported Group Home |
| ☐ Hostel/SRS Private Accommodation | ☐ Other, please specify |

Travel

How do you travel to work or to your day service? (Please tick the appropriate box)

- | | |
|--|--|
| ☐ Taxi | ☐ Pick up/ drop off by Parent/Family/Support Person |
| ☐ Transport provided by a provide | ☐ Independently use Public Transport |
| ☐ Walk | ☐ Assisted Public Transport |
| ☐ Drive own car | ☐ Other, please specify: |

Disability Conditions/Disability type(s)

Are there any important people in the Participant's life such as family member and their relationship?

Medication Information/Diagnosis/Health Concerns

Does the Participant require a Medication Chart?	☐ Yes	☐ No
Does the Participant require Mealtime Management?	☐ Yes	☐ No
Does the participant require Bowl Care Management?	☐ Yes	☐ No
Are there any issues with a menstrual cycle or is assistance needed?	☐ Yes If yes, please specify:	☐ No
Does the Participant require female hygiene assistance?	☐ Yes	☐ No
Does the Participant have Epilepsy?	☐ Yes	☐ No
Is the Participant an Asthmatic?	☐ Yes	☐ No
Does the Participant have any allergies?	☐ Yes	☐ No

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Is the Participant anaphylactic?	☐ Yes	☐ No
Do you give permission for our company's staff to administer band-aids in cases of a minor injury?	☐ Yes	☐ No
Does this participant require specific training for the support workers providing support?	☐ Yes	☐ No
Are there any other medication conditions that will be relevant to the care provided to this Participant?	☐ Yes	☐ No
IS there any specific trigger for community activities?	☐ Yes	☐ No

Safety Considerations

Does the Participant show signs or a history of unexpectedly leaving (absconding)?	☐ Yes	☐ No
Does the Participant show any signs or a history of respiratory depression?	☐ Yes	☐ No
Is this participant prone to falls or have a history of falls?	☐ Yes	☐ No
Are there any behaviours of concern? Eg: kicking, biting.	☐ Yes	☐ No
Is there a current Positive Behaviour Support Plan (PBS) in place?	☐ Yes	☐ No
Does the participant require communication assistance?	☐ Yes	☐ No
Is there any physical assistance or physical assistance preference for this Participant?	☐ Yes	☐ No



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Does the Participant have any expressive language concerns?

☐ Yes

☐ No

Does this Participant have any personal preferences & personal goals?

☐ Yes

☐ No

➤ **OHS & risk assessments.**

Refer to Form33. Participant Risk Assessment and Disaster Management Plan

Signature of participant:

Date:

[If signed by a Nominee:]

I confirm that this agreement has been explained to the person receiving the services (participant) and that they agree to this:

Signature of Nominee:

Date:

Signature on behalf of ADSS

Date: