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NDIS Participant Intake Form

*** ALL SECTIONS MUST BE COMPLETED AND SENT TO NDIS@LTTS.COM.AU ***

Section A: Participant Referral Details		
Full Name:		**D.O.B:** ____ / ____ / ________
Sex:	**Identified Gender:** *(if applicable)*	**Preferred Pronouns:**
Address:		**Town:**
Contact Number:	☐ Receive appointment reminders via text	
Email Address:		
NDIS Reference Number:	**NDIS Plan Dates:** ____ / ____ / ________ to ____ / ____ / ________	
Living Arrangement: ☐ Alone ☐ Family/Partner ☐ Supported Accommodation ☐ Other: ____________		
Does the participant identify as an Aboriginal or Torres Strait Islander? Yes ☐ No ☐		
Does the participant identify as Culturally and Linguistically Diverse? Yes ☐ No ☐		
If Yes, please specify:		
Preferred Language:	**Interpreter Required:** Yes ☐ No ☐	
Is this participant verbal? Yes ☐ No ☐		
Does this participant have communication difficulties/ require support for communication? Yes ☐ No ☐		
If Yes, please provide further detail here:		
Does this participant make their own decisions? Yes ☐ No ☐		
If No, detail who supports this paticipant in their decision making?		
Is the participant referring themselves? Yes ☐ No ☐ *(If No, complete Section B and C)*		

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Section B: Referrer/ Support Coordinator Details				
Name of Referrer/ Support Coordinator:				
Name of Organisation (*if applicable*)**:**				
Relationship to participant:	☐ Family (please specify member: _______________)	☐ Support Coordinator	☐ Case Manager	☐ LAC
Contact Number:		☐ Primary contact for all appointments		
Email Address:				☐ **Receives Reports**

Section C: Primary Alternative Contact/ Guardian Details			
Name of Alternative Contact/ Guardian (*if applicable*)**:**			
Name of Organisation (*if applicable*)**:**			
Relationship to participant:	☐ Family (please specify member: _______________)	☐ Guardian	☐ Other: _____________
Contact Number:			
Email Address:			☐ **Receives Reports**
Is there an active Guardian? Yes ☐ No ☐			
Guardianship Provisions:	☐ Health	☐ Accommodation	☐ Other: __________________________________
Secondary Alternative Contact Details			
Name of Alternative Contact/ Guardian (*if applicable*)**:**			
Name of Organisation (*if applicable*)**:**			
Relationship to participant:	☐ Family (please specify member: _______________)	☐ Guardian	☐ Other: _____________
Contact Number:			
Email Address:			☐ **Receives Reports**

Section D: Payment of Account Details
How is this account managed? ☐ NDIA ☐ Plan-Managed ☐ Self-Managed
Organisation Name that Manages this Account (if applicable):
Organisation Contact Details:
Are there any external agencies (OPG/CSO/etc) involved with this participant? Yes ☐ No ☐
**If Yes, please specify here:*
Is the participant's NDIS Plan funded by Early Childhood Early Intervention (ECEI)? Yes ☐ No ☐

Section E: Primary Disability
Provide details of the participant's primary diagnosis:
Provide details of the participant's other relevant medical history/ additional information:

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Section F: Services Seeking		
Occupational Therapy	☐ Ongoing Therapy ☐ Assessment *(choose which assessment)*	☐ Functional Capacity ☐ Comprehensive ☐ Supported Independent Living ☐ Assistive Technology ☐ Home Modifications Other: ______
Exercise Physiology	☐ Ongoing Therapy ☐ Assessment *(choose which assessment)*	☐ Functional Capacity ☐ Comprehensive Other: ______
Speech Pathology	☐ Ongoing Therapy ☐ Assessment *(choose which assessment)*	☐ Functional Communication ☐ Comprehensive ☐ Assistive Technology ☐ Feeding/Swallow/Mealtime Other: ______
Psychology	☐ Ongoing Therapy ☐ Assessment *(choose which assessment)*	☐ Psychosocial ☐ Cognitive ☐ Behavioural ☐ Comprehensive Other: ______
Specialist Positive Behaviour Support	☐ Positive Behaviour Intervention Supports (Capacity Building-Improved Relationships)	☐ With Restrictive practice ☐ Nil restrictive practice ☐ Uncertain
Allied Health Assistant	☐ Ongoing Assistance	☐ Occupational Therapy ☐ Speech Pathology
Group Programs	I am interested in further information relating to group programs for the following:	☐ Occupational Therapy ☐ Speech Pathology ☐ Psychology

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Section G: Service Delivery Screen	
Does the participant have access to Telehealth (online) facilities? Yes ☐ No ☐	
Does the participant require assistance to use Telehealth (online) facilities? Yes ☐ No ☐	
Delivery Preference:	☐ Face to Face ☐ Telehealth (online) ☐ Either

Section H: Eligibility Screen
Does the participant have Improved Relationships in their NDIS Plan? Yes ☐ No ☐
Does this participant display behaviours of concern that may warrant a Positive Behaviour Support Plan? Yes ☐ No ☐ *If yes, please describe the behaviours:*
Has the participant been involved, in the past or present, with the courts/legal system? Yes ☐ No ☐
If yes, we will contact for further details to assign the most appropriate therapist. *Please specify details here of involvement:*
Does this participant have any plans of service delivery within external organisations (Hospitals/ Inpatient Wards/ Ambulance/ Police/ Helplines/ etc)? Yes ☐ No ☐
If yes, please specify details here:

Section I: Advocacy Information	
Would the participant like to have an Advocate present at your appointment? Yes ☐ No ☐	
Name of Advocate:	**Contact Number of Advocate:**