|  |  |  |  |
| --- | --- | --- | --- |
| **Participant Name:** |  | **D.O.B:** |  |
| **NDIS Number:** |  |
| **ADDRESS** |  |
| **NDIS Plan Dates:** |   |
| **Phone Number:** |  | **E-mail:** |  |
| **Plan Details** | Plan Managed [ ]  Agency Managed [ ]  Self-Managed[ ]  |
| **Invoicing Details** (Self/Plan Manager Name, Email) |  |
| **Public Trustee** | **YES** [ ]  **NO** [ ]  |  |
| **Under Guardianship** | **YES** [ ]  **NO** [ ]  | **OPG**  |  **YES** [ ]  **NO** [ ]  |  |
| **Name** |  |
| **Role** |  |
| **Address** |  |
| **Contact details** |  |
| **Request for service:** | [ ]  **COS** [ ]  **Community Access** [ ]  **ABT** [ ]  **Domestic Assistance**[ ]  **Short Term Accommodation (STA)** [ ]  **Other:**  [ ]  **Use of Respite/STA House - $350 per night** [ ]  **Med prompt** |
| **SERVICE DETAILS:****Days required** |   |
| **Duration of service** |  |
| **Times preferred (if applicable)** |  |
| **Line Item** (from price guide) |  |
|  |  |
| **Current Behaviour Plan** | **YES** [ ]  **NO** [ ]  | **Attached** |  **YES** [ ]  **NO** [ ]  |
| **Current Diagnosis** |  |
| **Special Considerations:****Only if relevant to service** |  |
|  |
|  |
| **Medications if relevant** |  |
| **Allergies and eating requirements** |  |
| **Behaviours that may impact**  |  |
| **Communication Style** |  |
| **Ambulant** |  |
| **Equipment**  |  |
| **Wheelchair Cab required** |  |
| **Continence Aids required** |  |
| **Independent with toileting**  | **YES** [ ]  **NO** [ ]  |
|  |  |
|  |
| **Referee – Name and Role, company:** |  |
| **Contact Number:** |  | **E-mail:** |  |
| **Emergency name and contact:** |  |
| **Signature:** |  | **Date:** |  |

**Please add NDIS Plan Goals here:**

**Please attach NDIS ‘About ME’ page here**