|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**