

Intake form

| Participant Details: To provide the most appropriate support we need some details about the participant. | | | |
|--|---|--|----------------------|
| Participant's Name: | <input type="text"/> | Participant's DOB: | <input type="text"/> |
| Participant's Full Address: | <input type="text"/> | NDIS Number: | <input type="text"/> |
| Participant's Phone: | <input type="text"/> | Plan start date: | <input type="text"/> |
| Participant's Email: | <input type="text"/> | Plan end date: | <input type="text"/> |
| Indigenous Status: | <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islanders <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> None | Sex: | <input type="text"/> |
| | | Country of birth: | <input type="text"/> |
| Interpreter Required | <input type="checkbox"/> Yes <input type="checkbox"/> No | Language: | <input type="text"/> |
| Living Arrangement | | <input type="checkbox"/> Alone <input type="checkbox"/> Family/Partner <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Other | |
| Preferred method of contact (Check any/all that apply) | | <input type="checkbox"/> E-mail <input type="checkbox"/> Telephone <input type="checkbox"/> Text | |
| Is the client referring themselves? | | <input type="checkbox"/> Yes <input type="checkbox"/> NO (If No please provide details on the next few rows) | |
| Job Title/Role: | | <input type="checkbox"/> Family Member <input type="checkbox"/> Support Coordinator <input type="checkbox"/> Case Manager <input type="checkbox"/> LAC | |
| Referrer's Name: | <input type="text"/> | Referrer's Contact Number: | <input type="text"/> |
| Relationship to client: | <input type="text"/> | Referrer's Email Address: | <input type="text"/> |
| Primary Diagnosis <input type="text"/> | Please outline your diagnosis <input type="text"/> | | |



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| How does your diagnosis effect you or your client on a daily basis | <input type="text"/> |

| History | Mental Health Diagnosis | <input type="checkbox"/> No <input type="checkbox"/> Yes, if so please provide details. <input type="text"/> |
|--|---|---|
| Have you had involvement with the justice system | <input type="checkbox"/> No <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown |
| Have you had denied services in the last 2 years or had access to service limited/restricted because of your behaviour | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, explain <input type="text"/> |
| If you answered yes to any, are you happy for us to speak if needed with a recent service provider | <input type="checkbox"/> No <input type="checkbox"/> Yes | Contact details Name: <input type="text"/> Ph: <input type="text"/> e-mail: <input type="text"/> Name of service provider: <input type="text"/> |
| Medical conditions (if any) | <input type="text"/> | |
| Please provide a copy of the NDIS plan, or at least the following pages, | <input type="checkbox"/> Profile page <input type="checkbox"/> WRAP wellness recovery action plan (if available) | |



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| and other documents if available. | <input type="checkbox"/> Goals page/s-What I want to achieve. <input type="checkbox"/> Funding page |
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| Funds Management | |
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| Payment Method | <input type="checkbox"/> NDIA Managed? (My place portal) <input type="checkbox"/> Registered Plan management Provider <input type="checkbox"/> Self-managed <input type="checkbox"/> Plan Nominee |
| Details for invoices/payments | Name <input style="width: 100%;" type="text"/> |
| | Address <input style="width: 100%;" type="text"/> |
| | Phone <input style="width: 100%;" type="text"/> |
| | E-mail <input style="width: 100%;" type="text"/> |
| Who completed this form | Name <input style="width: 100%;" type="text"/> |
| | Address <input style="width: 100%;" type="text"/> |
| | Phone <input style="width: 100%;" type="text"/> |



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| | E-mail | |
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| Plan Nominee (Support Person) | <input type="checkbox"/> Not applicable |
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| | |
|-----------|--|
| Name | |
| Address | |
| Phone (s) | |
| E-mail | |

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| Support Coordinator | <input type="checkbox"/> Not applicable |
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| | |
|-----------|--|
| Name | |
| Address | |
| Phone (s) | |
| E-mail | |

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| Emergency Contact | <input type="checkbox"/> Not applicable |
|--------------------------|---|

| | |
|-----------|--|
| Name | |
| Address | |
| Phone (s) | |
| E-mail | |

Please e-mail this form to: admin@bbthrive.com.au





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