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| Purpose  |
| South West Disability Services (SWTAFE) seek your assistance to identify what is important to you and how you would like to be supported. This form is designed to obtain the relevant information to provide you with quality and individualised support.  |

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| Privacy and Confidentiality |
| Information disclosed in this form will **NOT** be disclosed to any outside person or organization without prior written or verbal consent from yourself or nominee/ representative, as per the Privacy Act 1988.SDWS may be obligated to collect data and details on behalf of the Government or other agencies, this information will be passed on when requested. Information may also be used or disclosed in circumstances related to public interest such as Law enforcement or health and safety related issues as noted within SWTAFE Privacy Policy.  |

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| How to complete this form. |
| This form should be completed by you, your parent/ caregiver, nominee or representative. Where appropriate it may also include support of a Support Coordinator and/or formal advocate. Stage 1- Complete online direct or complete Personal details and support requirements belowStage 2- ConsentStage 3- Office use only |

**STAGE 1**

|  |  |
| --- | --- |
| Online intake completed  | [ ]  Yes [ ]  No- complete Stage 1  |

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| Personal Details and Support Requirements |
| Full Name |       |
| Gender |       | Date of Birth  |       |
| Address |       |
| Suburb |       |
| Mailing Address (if difference to home address) |       |
| Home Phone  |       | Mobile  |       |
| Email Address |       |
| Cultural background  |       | Main language spoken at home |       |
| Interpreter required |  [ ]  Yes [ ]  No | Communication tools utlised |  [ ]  Yes [ ]  No Notes:       |
| Do you identity as: | [ ]  Aboriginal [ ]  Torres Strait Islander  |
| Preferred contact method  | [ ]  Telephone [ ]  text/ SMS [ ]  Email [ ]  Post [ ] Other       |
| Medicare Number  |       | Expiry Date |       |
| Healthcare Card |       | Expiry Date |       |
| Companion card  |       | Taxi Card  |       |
| Private Health Insurance | [ ]  Yes [ ]  No Details:       |
| State Trustee:  | [ ]  Yes [ ]  No Details:       |

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| Emergency Contact |
| Full Name |       | Relationship  |       |
| Address |       | Post Code  |       |
| Home phone  |       | Mobile  |       |
| Work Phone  |       | Email  |       |
| Interpreter Required  |  [ ]  Yes [ ]  No | Language spoken  |       |
| Notes:  |       |

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| --- | --- | --- | --- |
| Full Name |       | Relationship  |       |
| Address |       | Post Code  |       |
| Home phone  |       | Mobile  |       |
| Work Phone  |       | Email  |       |
| Interpreter Required  |  [ ]  Yes [ ]  No | Language spoken  |       |
| Notes:  |       |
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| Living Arrangements  |
| I currently live in | [ ]  Private home or Flat [ ] Emergency/ transitional housing[ ]  Supported accommodation Other:       |
| I currently live with | [ ]  on my own [ ] family/friends [ ]  Other      |

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| Funding  |
| NDIS Plan Dates |       | NDIS Number:  |       |
| Plan attached | [ ]  Yes [ ]  No  | Goals attached | [ ]  Yes [ ]  No |
| DHHS package  |       | TAC- ID Number |       |
| Other |       |
| Funding Contact: [ ]  Self [ ]  Other |
| Name  |       | Number  |       |
| Address  |       |
| Email  |       |

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| Daily Support Requirements  |
| Mobility |
| [ ]  Independent mobility [ ]  Requires support sitting[ ]  Requires support transferring[ ]  Requires support mobilising[ ]  Requires support positioning | Notes:       |
| Communication |
| [ ]  Uses verbal communication[ ]  Uses non-verbal communication[ ]  Vision Impairment[ ]  Hearing Impairment[ ]  Communication Aid[ ]  Hearing Aid | Notes:  |
| Eating and Nutrition  |
| [ ]  Eats independently [ ]  Requires assistance preparing meals [ ]  utilising utensils [ ]  Modified fluids [ ]  Modified foods [ ]  PEG- Percutaneous Endoscopic Gastrostomy [ ]  Swallowing Impairment [ ]  Diet plan Restrictions  | Notes:       |
| Toiletry & Personal Hygiene |
| [ ]  Requires assistance with Bladder management [ ]  Requires assistance with bowel management [ ]  Requires assistance with female hygiene | Notes:       |
| Personal Care |
| [ ]  Requires assistance with bathing/ showing [ ]  Requires assistance with grooming [ ]  Requires assistance with un/dressing[ ]  Requires assistance with skin care [ ]  Requires assistance with clothing choices[ ]  Requires podiatry assistance  | Notes:       |
| Independence  |
| [ ]  Requires assistance with choice making [ ]  Requires assistance with finances | Notes:       |
| What I like | What I dislike  |
|       |       |
| When I am happy I……  | When I am sad I……. |
|       |       |

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| Medical  |
| Condition  |  |
| Medication taken  | [ ] Yes [ ]  No Details       |
|  |
| Condition  |  |
| Medication taken  | [ ] Yes [ ]  No Details       |
|  |
| Condition  |  |
| Medication taken  | [ ] Yes [ ]  No Details       |

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| Behaviours |
| Behaviour |       |
| Behaviour strategies  |       |
|  |   |
| Behaviour |       |
| Behaviour strategies  |       |
|  |  |
| Behaviour Support plan (BSP) | [ ] Yes [ ]  No  | Consent to view BSP | [ ] Yes [ ]  No  |

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| Goals |
| Goal and strategies | Goal: Strategy:  |
| Goal and strategies | Goal: Strategy:  |

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| Consent  |
| By signing below I confirm that South West Disability Service have advised me of the following: * South West Disability Services Privacy and Confidentiality Policy
* My rights to access personal information
* My right to withdraw consent at any time
* My information may be shared with other services/agencies, including data collection by the government in order to improve quality of care
* If I am under the age of 18 or am unable to sign this document, a parent/carer/ nominee or representative may sign on my behalf.
 |
| Consent approval  |
| Full Consent  | [ ] Yes  |
|  |
| Part Consent  | [ ] Yes  |
| Please list consent approval  |       |
| No Consent  | [ ] Yes  |

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| **PERSONS or AGENCIES WITH WHOM INFORMATION CAN BE OBTAINED &/or SHARED**: |
| **Please add to the below list as required** |
| 1. SWTAFE specialist Teaching staff
 | [ ]  Obtain [ ] Share |
| 1. NDIA/Latrobe Community Health
 | [ ]  Obtain [ ] Share  |
|  | [ ]  Obtain [ ] Share  |
|  | [ ]  Obtain [ ] Share  |
|  | [ ]  Obtain [ ] Share  |
|  | [ ]  Obtain [ ] Share  |
|  | [ ]  Obtain [ ] Share  |

**STAGE 2**

|  |  |
| --- | --- |
| Intake check list  |  |
| The following has been shared with me in a way that I understand: | Please tick |
| * Eligibility criteria for entry to the service, and procedures for prioritising access
 | [ ]  |
| * Support which will be provided, how the support will be delivered, and how frequently my support profile will be reviewed
 | [ ]  |
| * How the participant accessing services can participate in decision making processes to assist the service to improve
 | [ ]  |
| * Information if I choose to exit the service in the future
 | [ ]  |

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| Declaration  |
| By signing below I agree that all the above information I have provided, is accurate and current. |
| Participant name  |       |
| Signature  |       | Date  |       |
|  |  |
| Carer/ representative name  |       |
| Signature  |       | Date  |       |

**OFFICE USE ONLY**

**STAGE 3**

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| Further information |
| Follow up: | Date  |
|       |       |

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| A copy of following has been provided  |
| [ ]  | Copy of participant handbook  |
| [ ]  | Copy of individual Service Agreement  |
| [ ]  | Copy of SDWS Privacy Policy  |
| [ ]  | Copy of ‘*Its ok to complain’* brochure  |
| [ ]  | Copy of Abuse and Neglect  |
| [ ]  | Copy of Advocacy list |

|  |  |
| --- | --- |
| Actions-Required  | **COMPLETED-** date  |
| [ ]  | Medication Management Form  |  |
| [ ]  | Medication Administration Record  |  |
| [ ]  | Personal Emergency Evacuation Plan  |  |
| [ ]  | Individual Support Sign off  |  |
| [ ]  | **Support Worker Training** **Notes:**  |  |

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| Department acknowledgement  |
| SWDS Representative  |       |
| Signature  |       | Date |       |