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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1.Participant Details | | | | | | | | | | | | | | | | |
| Name: | | | | | | | D.O.B: | | | | | | Gender: | | | |
| Address: | | | | | | | | | | | | | | | | |
| Mobile: | | | | | | Phone: | | | | | | | | | Email: | |
| Language Spoken at Home: | | | | | | | | | | | | | | | Interpreter Required:  Yes No | |
| Preferred Option for Communication: Email Post Phone | | | | | | | | | | | | | | | | |
| Do you identify as Aboriginal and Torres Strait Islander? LMS TRG TEMPLATE- DO NOT COPY Yes No | | | | | | | | | | | | | | | | |
| Residential Address (if different from above): | | | | | | | | | | | | | | | | |
| Postal Address (if different from above): | | | | | | | | | | | | | | | | |
| Is there a Guardianship and/or Administration order in place? Yes No | | | | | | | | | | | | | | | | |
| For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below: | | | | | | | | | | | | | | | | |
| Name of Parent/Guardian: | | | | | | | | | Primary Carer | | | | | | Yes | No |
| Lives with Participant | | | | | | Yes | No |
| Emergency Contact | | | | | | Yes | No |
| Relationship to participant: Parent Guardian Caregiver Other | | | | | | | | | | | | | | | | |
| Residential Address (if different from above): | | | | | | | | | | | | | | | | |
| Postal Address (if different from above): | | | | | | | | | | | | | | | | |
| Mobile: | | | | Phone: | | | | | | | | Email: | | | | |
| 2.Goals and Aspirations | | | | | | | | | | | | | | | | |
| What do you want to achieve for yourself – life skills, physically, socially etc? | | | | | | | | | | | | | | | | |
| Immediately LMS TRG TEMPLATE- DO NOT COPY | | |  | | | | | | | | | | | | | |
| In 3/6 months | | |  | | | | | | | | | | | | | |
| Next year | | |  | | | | | | | | | | | | | |
| I understand that:   * These records are owned by this organization. * Information within these records will be shared with other staff within the organization on and only when staff require the information to carry out their duties * I can ask to see records and receive a copy * Records are archived for a set period according to policy and procedure * I understand that all information obtained will be kept confidential.   To the best of my knowledge, the information provided in this form is true and correct. | | | | | | | | | | | | | | | | |
| 3.Health Care Information | | | | | | | | | | | | | | | | |
| Medicare Number: | | | | | | | | | | Expiry Date:  Reference Number: | | | | | | |
| Private Healthcare Provider: | | | | | | | | | | Membership number:  Reference Number: | | | | | | |
| Doctor name: | | | | | | | | | | Phone Number: | | | | | | |
| Address: | | | | | | | | | | | | | | | | |
| 4.Funding | | | | | | | | | | | | | | | | |
| NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIS managed participants) | | | | | | | | | | | | | | | | |
| NDIS Number: | | | | | | | | NDIS Plan Start Date: | | | | | | | | |
| Self-Managed | | | | | | | | Plan Managed | | | | | | | | |
| 5.Invoicing details | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | |
| Preferred Option for Communication: Email Post Phone | | | | | | | | | | | | | | | | |
| Phone number: | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | | | | |
| 6.Name of other current service providers | | | | | | | | | | | | | | | | |
| 1 | Name | | | |  | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | |
| Phone number/email | | | |  | | | | | | | | | | | |
| Emergency contact | | | |  | | | | | | | | | | | |
| Frequency of use | | | |  | | | | | | | | | | | |
| Type of service | | | |  | | | | | | | | | | | |
| 2 | Name | | | |  | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | |
| Phone number/email | | | |  | | | | | | | | | | | |
| Emergency contact | | | |  | | | | | | | | | | | |
| Frequency of use LMS TRG TEMPLATE- DO NOT COPY | | | |  | | | | | | | | | | | |
| Type of service | | | |  | | | | | | | | | | | |
| 3 | Name | | | |  | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | |
| Phone number/email | | | |  | | | | | | | | | | | |
| Emergency contact | | | |  | | | | | | | | | | | |
| Frequency of use | | | |  | | | | | | | | | | | |
| Type of service | | | |  | | | | | | | | | | | |
| 4 | Name | | | |  | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | |
| Phone number/email | | | |  | | | | | | | | | | | |
| Emergency contact | | | |  | | | | | | | | | | | |
| Frequency of use | | | |  | | | | | | | | | | | |
| Type of service | | | |  | | | | | | | | | | | |
| 7.Preferences | | | | | | | | | | | | | | | | |
| Preferred name: | | | | | | | | | | | | | | | | |
| Religious Requirements: | | | | | | | | | | | | | | | | |
| Cultural Requirements: | | | | | | | | | | | | | | | | |
| Communication device: | | | | | | | | | | | | | | | | |
| Physical Assistance: | | | | | | | | | | | | | | | | |
| Other Considerations: | | | | | | | | | | | | | | | | |
| 8.Property register | | | | | | | | | | | | | | | | |
| Date | | Item | | | | | | | | | Qty | | | Location | | |
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| 9.Disability / Medical Conditions Including Any Diagnosis If Relevant | | | | | | | | | | | | | | | | |
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| 10.Health issues and how to escalate urgent health situation | | | | | | | | | | | | | | | | |
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| 11.Emergency and disaster plan | | | | | | | | | | | | | | | | |
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| 12.Escalation mechanism in the event of emergency | | | | | | | | | | | | | | | | |
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| 13.Any other information | | | | | | | | | | | | | | | | |
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I understand that:

● These records are owned by this organisation.

● Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties

● I can ask to see records and receive a copy

● Records are archived for a set period according to policy and procedure

● I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_