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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 |
|   |

I understand that:

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● 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_