Participant Intake Form

Blue Wren Home Nursing

1.Participant Details		
Name:	D.O.B:	Gender:
Preferred name:	Cultural background:	
Address:		
Postal Address (if different from above):		
Email:	Mobile:	
Language Spoken at Home:	Interpreter Required: ☐ Yes ☐ No	
Preferred Option for Communication: ☐ Email ☐ Post ☐ Phone		
Do you identify as Aboriginal and Torres Strait Islander? ☐ Yes ☐ No		
NDIS Funding type:	☐ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIS managed participants) ☐ Self-Managed ☐ Plan Managed	
NDIS Numb	NDIS start date: NDIS end date:	
Invoicing details	Name: Preferred option for communication: Phone number: Email: Address:	

2.Representative Details		
Name of Representative:		
Lives with Participant	☐ Yes	☐ No
Relationship to participant ☐ Parent ☐ Guardian ☐ Caregiver ☐ Other (please specify):		
Address:		
Phone:		
Email:		
Preferred method of contact ☐ Email ☐ Post ☐ Phone		

3.Emergency Contact Details

Is emergency contact the same as above? ☐ Yes ☐ No		
Name of emergency contact:		
Lives with Participant	☐ Yes	☐ No
Relationship to participant ☐ Parent ☐ Guardian ☐ Caregiver ☐ Other (please specify):		
Address:		
Phone:		
Email:		
Preferred method of contact	☐ Email ☐ Post ☐ Phone	

4.Health Care Information

Medicare Number:	Expiry Date: Reference Number:
Private Healthcare Provider:	Membership number: Reference Number:

5.About the Participant

Living situation	☐ Living alone in my own home ☐ Living with my family ☐ Supported Accommodation ☐ Temporary ☐ Other:
Types of disability:	
Religious/ cultural requirements:	
Does the participant need physical assistance equipment or support?	☐ Yes – please detail: ☐ No
Does the participant need assistive devices for communication?	☐ Yes – please detail: ☐ No
Is the participant visually impaired?	☐ Yes – please detail: ☐ No
Does the participant have any dietary requirements?	☐ Yes – please detail: ☐ No

Does the participant have any swallowing difficulties?	☐ Yes – please detail: ☐ No
Other considerations:	
Does the participant have a current behavioural support plan?	☐ Yes ☐ No
If yes, please provide the details of your behaviour practitioner	Practitioner's name: Contact number: Address:
Medical condition/diagnosis:	
Medical condition/diagnosis:	
Medical condition/diagnosis:	
Allergies:	
Please provide details of your medical practitioner	Name: Contact number: Address:

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	
	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.Goals	
What do you want to achieve for yourself – life skills, physically, socially etc?	
Short term goals:	
Long term goals:	

8.Consent	
Please sign below to show that you agree with the information in this client intake form	
Intake form was completed by:	
Participant Signature:	
Parent / caregiver signature:	
Name of the person signing:	
Relationship to the participant, if not the participant:	
Date:	

VERSION CONTROL TABLE

Drafted By	Version Control Month & Year	Next Review Month & Year	Reviewed and authorised by	Amendment
Healthcare Consulting	1st of August 2024	1st of August 2025		