Create
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Intake Form

NDIS Participant Details

Title/Full Name	
D.O.B	
NDIS number (This is a 9 digit number usually starting with 43)	
Medicare Number	
Centrelink Number	
Plan Start Date	
Plan End Date	
Address	
Home Phone	
Mobile	
Email	

Cultural Background

Are you Aboriginal and/or Torres Strait Islander? (Please circle)	Aboriginal Torres Strait Islander Both Neither

Main Language at home?	
Cultural or religious affiliations	
Interpreter required?	Yes / No
Comments	
Cultural Services Involved	

Consent

Note for staff:
Please ensure you have explained to the participant why we collect personal information and ensure they understand.

Collecting/storing personal information	Yes / No
Sharing Personal information internally	Yes / No
Sharing Personal information externally	Yes / No
Use of name in marketing material	Yes / No
Use of photo in marketing material	Yes / No
Use of name on social media sites	Yes / No
Use of photo on social media sites	Yes / No
Participant Signature Note for staff: Please ensure you have explained to the participant why we collect personal information and ensure they understand.	

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Medical Information

Diagnoses	
Do you take medications? If yes, each service provider that we connect you with may ask for a full list and dosage amounts	Yes / No
Medication names and dosage if applicable:	
Do you have any allergies?	Yes / No
If "yes" to allergies please provide details	
Do you have any support plans, such as those for health or behaviour?	Yes / No
If "yes" to any support plans please provide details	

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Emergency Contacts

Contact 1

Name	
Phone	
Work	
Email	
Relationship	

Contact 2

Name	
Phone	
Work	
Email	
Relationship	

Professional Involved:	

Person Responsible

(For individuals under the age of 18 or Guardianship/Court Order in place)

Participants Full Name	
Relationship to Individual	
Responsibility Type	Parent Spouse Legal guardian Public guardian Sibling

Home Address	
Postal Address	
Home phone	
Work phone	
Mobile	
Email	

I agree to be the “Person Responsible” for the Participant whose name appears above.

Name	
Signature	
Date	

Your Consent

I,

Participant's name/Person Responsible	

state that information given to Create A Sense of Place is true and correct. I understand that all information provided will remain private and confidential.

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Name	
Signature	
Date	

Representative Name	
Signature	
Date	

Please seek verbal consent if Participant/ Person Responsible is unable to sign

Reason for verbal consent	
Date of verbal consent	

How to Best Support You

How did you hear about us? (Please circle)	NDIA Portal NDIA Planner, Liaison Officer or Local Area Coordinator Word of Mouth Internet Search Another Service Provider
From which service provider did you hear about us?	

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What are your top 3 goals you would like to achieve?

Goal 1	
Goal 2	
Goal 3	

What's Important to you?	
What would you like us to know about you and share with other providers?	

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Your Timetable

What would you like us to know about you and share with other providers?

Monday - AM	
Monday - PM	
Tuesday- AM	
Tuesday - PM	
Wednesday - AM	
Wednesday - PM	
Thursday - AM	
Thursday - PM	

Friday - AM	
Friday - PM	
Saturday - AM	
Saturday - PM	
Sunday - AM	
Sunday - PM	
Comments	

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Keeping In Touch

We want to make sure lines of communication are always open. We want everyone to share and celebrate the success of goal progress and achievements.
Please tell us your preference for receiving feedback on goal progress, and goal achievement as well as keeping up to date with the daily activities. We have provided a few examples for you.

Type of Communication?	Face to Face Emails Texts Phone calls Letter/Report
How Often	Daily Weekly Fortnightly Monthly
Comments	

CASOP Coordinator email address (for form submission storage)	
Coordinator Name	