



Create

# A Sense of Place

## Collecting Information & Emergency Contact Details

Support to be Provided: Community Participation Supports

### Personal Information

Title/Full Name	
Date of Birth	
NDIS Number	
Medicare Number	
Centrelink Number	
Address	
Home Phone	
Mobile	
Email	

Are you Aboriginal and/or Torres Strait Islander?	Yes / No
Main Language at home?	
Cultural or religious affiliations	
Interpreter required?	
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
<b>Participant Signature</b> Note for staff: Please ensure you have explained to the participant why we collect personal information and ensure they understand.	

## 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
Do you have any allergies?	Yes / No
Do you have any support plans, such as those for health or behaviour?	Yes / No

## Emergency Contacts

### Contact 1

Name	
Phone	
Work	
Email	
Relationship	

### Contact 2

Name	
Phone	
Work	
Email	
Relationship	

Professional Involved: i.e. GP, case worker, teacher, mentor, clinicians	
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## Person Responsible

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

Participants Full Name	
Person Responsible Name	
Relationship to Participant	
Responsibility Type ie Parent, Spouse, Guardian etc	

Home Address	
Postal Address If different	
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,

Name (Participant/Person Responsible)	
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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.

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? ie Portal, Internet, Other Provider etc	
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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?	

## 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.

We can offer all different ways of staying in touch. Please tell us your preference of communication

Type of Communication? ie Face to Face, Email, Phone, Text, etc	
Comments	

CASoP Representative email address (for form submission storage)	
CASoP Representative Name	