Participant Profile & Intake Form

Referral Form Received ☐ Yes ☐ No Referred By/From:

1 Participant Profile - Personal Information

Name

Date of Birth

Street Address

Postcode

Postal Address

Postcode

Home Phone Number

Mobile Number

Email Address

Gender

Country & Place of Birth

Language Spoken at Home

Understanding of English ☐ Yes ☐ No

Needs an Interpreter ☐ Yes ☐ No

Preferred Method of Communication

☐ Phone ☐ Text ☐ Email ☐ Easy Read ☐ Other

Aboriginal or Torres Strait Islander

☐ Aboriginal ☐ Torres Strait Islander ☐ Other

Cultural Preferences

Worker Preferences

Is there a Guardian and/or Administration order in place? ☐ Yes ☐ No

If yes, please give details

2 Participant Diagnosis /Medical History

Diagnosis - Primary & Secondary (if applicable)

Any additional disability or medical information

Medical Conditions			Comments
Allergies	Yes	No	
Epilepsy	Yes	No	
Asthma	Yes	No	
Heart Conditions	Yes	No	
Diabetes	Yes	No	
Phobias	Yes	No	
Other	Yes	No	

3 Participant Information

Provide Details of things that the Participant Likes and Dislikes
(this could include hobbies, activities, social/emotional needs, noises, crowded places etc)

Participant Expressed Needs

4 Participant's Support Network Contact Information

	Phone Number	Relationship
Emergency Contact 1 Name		
Emergency Contact 2 Name		
Guardian Name		
Advocate/Support Person Name		
GP Name		
Allied Health 1 Name		
Allied Health 2 Name		
Other Name		

5 Participant Living and Income Arrangements

Does the Participant Live alone? ☐ Yes ☐ No Details

Housing type:

☐ Department of Housing ☐ Private Rental ☐ Owner Occupier

Participant Income Source ☐ Disability Pension ☐ Other Details

Is the Public Trustee Involved with the Client? ☐ Yes ☐ No Details

6 Funding Supports

NDIS Participant Number

Copy of NDIS Plan: ☐ Yes ☐ No

If NDIS, NDIS billing is:

☐ NDIA Managed ☐ Self Managed ☐ Plan Managed

If Plan Managed, Plan Manager Details:

Name

Phone

Email

7 Risk Assessment for Home Visit

	Yes	No	Details	Risk Rating
Does the participant live alone?	☐	☐		
Are additional persons/carers expected to be present at the time of the visit?	☐	☐		
Is the participant or others known to be potentially aggressive or violent?	☐	☐		
Is there evidence that household members may be under the influence of drugs or alcohol?	☐	☐		
Are there any weapons in the home?	☐	☐		
Does the Participant have any pets?	☐	☐		
Are the premises easily accessible from the street?	☐	☐		
Does the participant, or other occupants smoke?	☐	☐		

Controls Implemented for Risks Identified

Overall residual risk rating after controls implemented:

Likelihood	Consequence				
	Insignificant	Minor	Moderate	Major	Severe
Almost Certain Expected to occur in most circumstances	M	H	H	E	E
Likely Could happen regularly	M	M	H	H	E
Possible Might happen at sometime	L	M	M	H	E
Unlikely Could happen rarely	L	M	M	M	H
Rare Could happen but probably never will	L	L	M	M	H

Low (L)	Manage and monitor with normal operational management practices. Ensure regulatory compliance and site-specific rules are met.
Medium (M)	Will require operational planning. Risk should be managed and monitored regularly.
High (H)	Will require operational pre-planning. Must have considerable management to reduce as low as reasonably practicable.
Extreme (E)	Immediate action required by Executive Management Team. Do not restart activity until risk has been controlled.

8 For Office Use Only - Assessment Outcomes & Service Provision

Consent obtained to seek further information to discuss participant with other agencies? ☐ Yes ☐ No

Request for Medical Information ☐ Yes ☐ No

Consent Forms Completed ☐ Yes ☐ No

ICAS Eligibility Criteria for entry to the service and procedures for prioritising access have been explained to client: ☐ Yes ☐ No

ICAS is able to provide supports to the participant: ☐ Yes ☐ No

Referral to other provider made: ☐ Yes ☐ No

Participant has requested the following ICAS services:

☐ Support Coordination ☐ Plan Management ☐ Provision of Supports

Action Checklist

Complete the action checklist to list follow up actions and services that are to be arranged for the participant.

Service Details/Frequency

Support Hours

Support Needs

Allied Health Services

Signature of Assessor

Position of Assessor

Date