

Participant Details			
Once completed please email this form to servicedelivery.vic@completenursing.com.au			
How did you hear about Complete Nursing and Home Care?			
Date of Intake		Referred By	
Participant First Name		Participant Last Name	
Gender		Date of Birth	
Languages Spoken		Cultural Origin	
Are you Aboriginal or Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Address		Suburb & Postcode	
Type of Address		Living Arrangements	
Home Phone		Mobile Number	
Email Address			
Are there any court orders/custody arrangements/restraining orders in place?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Participants Contact Person and Emergency Contact			
Primary Contact Person			
First Name		Last Name	
Address		Suburb & Postcode	
Email Address			
Relationship to the Participant			
Emergency Contact Person			
First Name		Last Name	
Address		Suburb & Postcode	
Email Address			
Relationship to the Participant			
Provider Details and Funding			
NDIS Number		NDIS Plan Start Date	
Contact Name		NDIS Plan End Date	
Email Address			
<input type="checkbox"/> Self-Managed		<input type="checkbox"/> Plan Managed	
<input type="checkbox"/> NDIA Managed			
If Plan Managed, provide Financial Intermediary details			
Invoice to (email address)			
Support Coordinator Name		Mobile Number	
Organisations Name		Phone Number	
Email Address			
Medical History and Details			
Primary Disability			
<input type="checkbox"/> Acquired Brain Injury	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Deafblind (Dual Sensory)
<input type="checkbox"/> Dementia	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Genetic/Chromosomal Disorder
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Intellectual	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Neurological (including Epilepsy and Alzheimer's)
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Physical	<input type="checkbox"/> Speech	<input type="checkbox"/> Vision Impaired
Primary Disability Details			
Secondary Disability			
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Deafblind (Dual Sensory)	<input type="checkbox"/> Dementia
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Intellectual
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Neurological (including Epilepsy and Alzheimer's)	<input type="checkbox"/> Psychiatric	
<input type="checkbox"/> Physical	<input type="checkbox"/> Speech	<input type="checkbox"/> Vision Impaired	
Secondary Disability Details			

Additional Information							
Does the Participant have any behaviours of concern?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide the Behaviour Support Plan							
Does the Participant require communication support?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide communication plan and contact person							
Does the Participant require meal/swallowing support?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide details							
Does the Participant have a health condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide details							
Does the Participant require support with medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide details							
Support Requirements							
Days and Times Required							
Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
Night							
Support Worker Preferences							
What are the expectations of the Support Workers?							
Will transport be required?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>Note: that all transport will be invoiced to the participant directly and will not be drawn from the NDIS plan unless specifically funded</i>							
Type of Support Required							
<input type="checkbox"/> Community Access				<input type="checkbox"/> Assistance with Self-Care			
<input type="checkbox"/> Personal Care				<input type="checkbox"/> Domestic Activities			
<input type="checkbox"/> Innovative Community Participation (Art Therapy)				<input type="checkbox"/> Innovative Community Participation (Dog Therapy)			
<input type="checkbox"/> Active Overnight				<input type="checkbox"/> Sleepover			
Does the Participant require a Registered Nurse of an Enrolled Nurse?						<input type="checkbox"/> Yes <input type="checkbox"/> No	