Flintwood Disability Services Inc
PO Box 2501
North Parramatta NSW 1750
Tel: 02 9630 1777 Fax: 02 9630 1788

INTAKE FORM

1. Personal Details

NAME: ____D.O.B: ____________________

ADDRESS: ____ PHONE: ____________________

____

SEX: MALE [ ] FEMALE [ ]

COUNTRY OF BIRTH: ____

LANGUAGE SPOKEN AT HOME: ____

INTERPRETER REQUIRED: YES [ ] NO [ ]

CULTURALLY / LINGUISTICALLY DIVERSE BACKGROUND: YES [ ] NO [ ]

LANGUAGE: ____

DETAILS: ____

RELIGION: ____

MEDICARE NUMBER: _ _ _ _ _ _ _ _ _ _

PENSION NUMBER: ____

PARENT/GUARDIANS: ____

FATHERS NAME: ____

MOTHERS NAME: ____

SIBLINGS NAMES:

1.____

2.____

3.____

4.____

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2. Contacts

MOTHER'S Age Range

25-44 [ ]

45-64 [ ]

65 > [ ]

Phone Numbers

Home: ____________________

Work: ____________________

Mobile: ____________________

Fax: ____________________

Email: ____________________

FATHER'S Age Range

25-44 [ ]

45-64 [ ]

65 > [ ]

Phone Numbers

Home: ____________________

Work: ____________________

Mobile: ____________________

Fax: ____________________

Email: ____________________

Emergency Contact

Name: ____________________

Relationship: ____________________

Address: ____________________

____________________ PostCode: ____________________

Emergency Phone Numbers

Home: ____________________

Work: ____________________

Mobile: ____________________

INTAKE FORM

SECOND EMERGENCY CONTACT

Name: ____

Relationship: ____

Address: ____

____PostCode:______________

Second Emergency Phone Numbers

Home: ____

Work: ____

Mobile: ____

3. Services Information

SERVICES RECEIVED:

RESPITE CARE: (Centre Based / Flexible Packages) **YES [ ] NO [ ]**

Name of Service: ____

Address: ____

____

Phone: ____

Contact Person: ____

RECREATIONAL: YES [ ] NO [ ]

Name of Service: ____

Address: ____

____

Phone: ____

Contact Person: ____

DAY ARRANGEMENTS / SCHOOL/ WORK: YES [ ] NO [ ]

Name of Service: ____

Address: ____

____

Phone: ____

Contact Person: ____

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HOME CARE: YES [ ] NO [ ]
DADHC CASE WORKER YES [ ] NO [ ]
Name: ______________________________
Phone: ______________________________

SPECIALIST SERVICES: (eg. Physio, OT) YES [ ] NO [ ]
Name: ______________________________
Specialist Type: ______________________________
Phone: ______________________________
Name: ______________________________
Specialist Type: ______________________________
Phone: ______________________________

4. Medical/Health Information

MEDICAL PRACTITIONER: ______________________________
ADDRESS: ______________________________
____
PHONE: ______________________________
CURRENT HEALTH ISSUES: ______________________________
____
____

SIGNIFICANT MEDICAL ISSUES: ie. Family History
____
____
____
____

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MEDICATION Yes [ ] No [ ]
** Medication Forms required

CURRENT HEALTH SUPPORT REQUIREMENTS ie. Bowel Care, Nutrition, Asthma, Epilepsy, Diabetes, Allergies, Mobility issues.

DETAILS: (Care Plan Required).

____
____
____
____
____
____
____
____
____
____
____
____
____

5. Psychological/Behavioural Issues

* Please note a behavioural plan will be required

TYPE OF BEHAVIOUR	YES	NO	NOTES
Aggression			
Inappropriate Sexual Behaviour			
Wandering off with Risk to Safety			
Self Injurious Behaviour			
Property Damage			
Obsessive Behaviour			
Screaming / Spitting			
Other			

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6. Communication

Language Skills:

- Understanding

- Expressive:

7. Domestic Skills

Cooking & food preparation: ____
____
____
Washing up / setting table: ____
____
____
____
Cleaning / vacuuming etc: ____
____

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Communication Aids:

8. Living Skills

Personal Care Skills	**Level of Independence /Need for help**
Eating	
Washing / Bathing	
Dressing	
Handling Money	
Toileting	
Shopping	

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9. Safety Skills

Negotiating Stairs: ______________________________
Pain perception: ______________________________
Avoidance of Hot Substances: ______________________________
Road Safety Skills: ______________________________
Sexual Awareness: ______________________________
Knows own name: ______________________________
Knows address: ______________________________
Stranger Danger: ______________________________
Awareness of Poisons / Chemicals: ______________________________
Awareness of sharp objects: ______________________________
Self Protective Behaviours ______________________________

10. Diet

Preferred Food: ______________________________
____

Dislikes:______________________________
____
____

Special Requirements: ** Mealtime Management Plan Required
____
____
____

11. Recreation and Leisure

Preferred Outdoor Activities: ______________________________
____
____
____

Preferred Indoor Activities: ______________________________
____
____
____

Limitations on activity: ______________________________
____
____
____

Water Activities / Considerations:
____
____

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12. Relationships

(Friends, Peers, Partners, Support people)

13. Other Considerations for Care / Management

This form was completed by:

______________________________ ______________________________

Name: Relationship to Service User

______________________________ ______________________________

Signature: Date:

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REPORT—Assessment of Support Needs

Details:

Name:____

Signed:____

Date: ____