# Participant contact Information

|  |  |
| --- | --- |
| Your name |  |
| Preferred name |  |
| Date of birth |  |
| Gender / Pronoun |  |
| Interpreter Required YES/NO (Language) |  |
| Phone |  |
| Email |  |
| Address |  |
| Postal (if different) |  |
| Can we safely send an SMS or email to these contact details? Yes/ No | |
| Do any court orders apply to you? |  |
| Workplace / School |  |
| Occupation / Year level |  |
| Your usual mode of transport (car, PT) |  |
| How did you hear about GAS? |  |
| When would you like to start? |  |

# Referral information

|  |  |
| --- | --- |
| Referral date |  |
| Referring agency |  |
| Contact person |  |
| Email |  |
| Phone |  |
| Reason for referral |  |
| Diagnosis / disability (if applicable) |  |

# Emergency contact information

|  |  |
| --- | --- |
| In case of emergency please contact (Parent, Guardian, Advocate, Agency, Friend) | |
| Name |  |
| Phone |  |
| Email |  |
| Address |  |
| Relationship to you |  |
| Have they been informed of this role YES/NO |  |

# Billing information

|  |  |
| --- | --- |
| Funded by (send invoice to) |  |
| NDIS Disability Care Number (if applicable) |  |

# Support needs

|  |  |
| --- | --- |
| What brings you to GAS? |  |
| Do you have any other support right now? |  |
| Do you have any specific needs regarding your culture, gender, religion? |  |
| Which GAS activities interest you most? |  |

# Safety needs

|  |  |
| --- | --- |
| Do you have a Safety Plan? |  |
| Do you have a Behaviour Support Plan? |  |
| Can you communicate unaided? |  |
| Do you require mobility aids? |  |
| Do you require personal care assistance? |  |
| Can you self-administer medication? |  |
| Are you able to understand and follow safety instructions? |  |
| Are you comfortable in outdoor environments? |  |
| Are there any places or activities we should avoid? |  |
| What strategies do you use to calm and regulate your nervous system? Do you need assistance? |  |
| Do you have difficulty with specific triggers? |  |
| Have you deliberately injured or harmed yourself? |  |
| Have you experience suicidal ideation? |  |
| Have you been verbally or physically violent towards others? |  |
| Have you ever absconded whilst in care? |  |
| Do you have a heightened interest in fire or pose a fire risk? |  |
| Are you able to attend free from alcohol and/or illicit drugs? |  |
| Is there anything else you would like GAS staff to know (in regard to keeping you safe)? |  |

# Medical history

|  |  |
| --- | --- |
| Medicare number |  |
| Medicare expiry date |  |
| Private Health Insurance YES/NO | Ambulance cover YES/NO |
| Are you vision impaired? YES/NO | Are you hearing impaired? YES/NO |
| Do you have asthma? YES/NO | Do you have an Asthma Action Plan? YES/NO |
| Do you have diabetes? YES/NO | Do you have a Diabetes Management Plan? YES/NO |
| Do you have epilepsy? YES/NO | Do you have an Epilepsy Management Plan? YES/NO |
| Do you have allergies? YES/NO | Do you have an Allergy or Anaphylaxis Action Plan? YES/NO |
| What are you allergic to? |  |
| Do you have a heart condition? YES/NO | Do you have any problems with your balance? YES/NO |
| Do you have any back, knee, ankle, shoulder problems? |  |
| Has a doctor placed any restrictions on your activity? |  |
| How far or for how long can you walk without stopping? |  |
| How far can you swim without stopping? |  |
| Please list all other medical conditions and illnesses. |  |
| Instructions for GAS staff (if applicable). |  |

# Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Dose | Frequency | Purpose of medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Other contacts

|  |  |
| --- | --- |
| **General Practitioner** | |
| Full name |  |
| Clinic name |  |
| Address |  |
| Phone |  |
| Email |  |

|  |  |
| --- | --- |
| **Specialist Medical or Allied Health Practitioner (if applicable)** | |
| Full name |  |
| Their role (Paediatrician, psychiatrist, etc.) |  |
| Clinic name |  |
| Address |  |
| Phone |  |
| Email |  |

|  |  |
| --- | --- |
| **Support Coordinator / Key Worker / School (if applicable)** | |
| Full name |  |
| Their role |  |
| Agency |  |
| Address |  |
| Phone |  |
| Email |  |