Disability Services - Intake

Once completed, send to [services@futurebeacons.com.au](mailto:services@futurebeacons.com.au)

Call 03 9700 1351 if you are experiencing difficulties filling out this form.

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| --- | --- | --- | --- |
| Referral Date |  | | |
| Participant or their Plan Nominee consent to receive services from Future Beacons | | | Yes/ No |
| Participant or their Plan Nominee consent to have the information in this referral kept with Future Beacons until further notice | | | Yes/ No |
| Participant or their Plan Nominee consent to have their information shared with relevant parties such as; Allied Health, GP, Psychiatrist and others | | | Yes/ No |
| Participant or their Plan Nominee consent to have their file audited and/or be part of the interview or neither | | | File only/ Interview only/ Both/ Neither |
| Participant Details | | | |
| First Name |  | Last Name |  |
| Gender | Male/ Female/ Other | Date of Birth |  |
| Phone # |  | Email Address |  |
| Home Address |  | | |
| Disability Diagnosis |  | Aboriginal and/or Torres Strait Islander (ATSI) Background |  |
| Culturally and Linguistically Diverse (CALD) Background |  | Interpreter Required? If Yes, What Language? |  |
| Services Required |  | Additional Information  (Etiquettes/ Customs/ Requests) |  |
| Safety Concerns | | | |
| Does the Participant or Anyone else at the property known to be aggressive or violent? If yes, please specify; | | | Yes/ No |
| Does the Participant or Anyone else at the property known to drink alcohol excessively or have drugs history? If yes, please specify; | | | Yes/ No |
| Does the Participant or Anyone else at the property store or use firearms? If yes, please specify; | | | Yes/ No |
| Does the Participant or Anyone else at the property have infectious disease such; chicken pox, shingles, gastro, covid-19 or others? If yes, please specify; | | | Yes/ No |
| Are there risks related to pets or animals, if existed at the property? If yes, please specify; | | | Yes/ No |
| Does the Participant requires self-care? If yes, kindly forward a copy of their continence assessment to us. | | | Yes/ No |
| Does the Participant uses a wheelchair? If yes, kindly forward a copy of the OT assessment to us. | | | Yes/ No |
| Does the Participant requires assistance in taking medication? If yes, kindly forward a copy of their medical assessment to us. | | | Yes/ No |
| Does the Participant has a behavioural support plan in place? If yes, kindly forward a copy of the plan to us. | | | Yes/ No |
| Does the Participant has a risk assessment? If yes, kindly forward a copy of the assessment to us. | | | Yes/ No |
| Are there any other safety concerns we should be aware of before visiting the property? If yes, please specify; | | | Yes/ No |
| Next of Kin Details | | | |
| First Name |  | Last Name |  |
| Phone # |  | Email Address |  |
| Home Address |  | | |
| Relationship to the Participant | Plan Nominee/ Carer/ Emergency/ Representative/ Other | | |
| Referrer Details or Support Coordinator | | | |
| First Name |  | Last Name |  |
| Phone # |  | Email Address |  |
| Orgnisation |  | Working Days |  |
| Funding Details | | | |
| NDIS Package | Yes/No | NDIS Reference Number |  |
| Plan Start Date |  | Plan End Date |  |
| Other Funding |  | | |
| Plan Manager | | | |
| First Name |  | Last Name |  |
| Phone # |  | Email Address |  |
| Orgnisation |  | Working Days |  |