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| INTAKE / ENQUIRY FORM |
| Sunbird Home Care: 1800 13 47 11 |
| Please email referral to: [info@sunbirdhomecare.com.au](mailto:info@sunbirdhomecare.com.au) |

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| PARTICIPANT | |
| Name: |  |
| DOB: |  |
| Mobile: |  |
| email: |  |
| NDIS Number: |  |
| NDIS Plan Dates: |  |
| Address: |  |
| Medicare Card |  |
| General Practitioner |  |

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| SERVICES FUNDED BY | |
| Self Managed NDIS Plan:  Date of current plan: | |
| NDIA Agency Managed Plan: | |
| Other Plan Manager: | |
| Plan Manager: | Name: |
| Mobile: |
| email: |
| No NDIS Plan but  has funding from: |  |
| email for invoice: |  |

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| CONSENT FOR SERVICE | |
| Name: |  |
| Date: |  |
| Designation: |  |
| Signature:  If unable to sign please record as UTS |  |
| Mobile: |  |
| Address: |  |
| email: |  |

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| CARER / GUARDIAN / OPG / OTHER | |
| Name: |  |
| Date: |  |
| Designation: | Carer /  Guardian /  OPG /  Other |
| Signature: |  |
| Mobile: |  |
| email: |  |

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| PARTICIPANT DIAGNOSIS / BACKGROUND INFORMATION / FAMILY / PETS / HOBBIES / ALLERGIES / MEDICATION |
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| GENERAL INFORMATION |
| Level Of Care  Independent – minor assistance required  Partially Independent – moderate assistance required  Dependent – full assistance required |
| Assistance required  Personal Care (bathing, dressing, toileting)  Hours / week  Meal Support including food preparation  Hours / week  Community participation support  Hours / week |
| Health Support  Support Worker  Indigenous Health Practitioner  Enrolled Nurse /  Registered Nurse  Clinical Nurse Consultant –  Credentialled Diabetes Nurse  Continence Nurse  Wound Nurse  Nurse Practitioner  Dietitian  Exercise Physiologist  General Practitioner  Music Therapist  Occupational Therapist  Physiotherapist  Speech Therapist |

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| URGENCY / RISKS |
| Is there any urgency for this referral?  Please indicate time frame and details of urgency. |
| Are there any potential risks for the staff during the assessment?  eg. Cheeky dogs or behavioural issues? Please note if known. |