Liberty Disability Services

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NDIS Provider # 4050036215

Community Mentor / Personal Care Intake Questions

Once we receive this form we will be in touch to discuss the detail, please don't stress if you can't answer everything - we will call and go over everything.

1. **Participant name** * _____ 2. **NDIS Number** _____

4. **Participant DOB** * _____ **Email address** * _____

5. **Participant Address** _____

6. **Participant Phone Number** _____ **Secondary Contact Number** _____

7. **Plan Start date** _____ **Plan end date** _____

Cultural Background _____ **Preferred Language** _____

11. Preferred method of contact (please note we are happy to use SMS and email if you have anxiety) we will meet with you when you feel comfortable and where you feel comfortable.
Check all that apply.

- [ ] Phone call
- [ ] Email
- [ ] SMS
- [ ] Other: _____

12. **Disability** *
Check all that apply.

- [ ] Intellectual Disability
- [ ] Physical Disability
- [ ] ASD
- [ ] Profound Hearing Loss
- [ ] Legally Blind
- [ ] Other: _____

13. **Tell us about yourself**

_____

_____

_____

14. **Do you get anxious / stressed etc..... what happens, when that happens - what normally causes this (triggers) ie. being touched, loud noises etc.**

_____

_____

_____

_____

15. **Sometimes people when they get very upset due to their disability find it difficult to find their calmness or sometimes can lash out without meaning too - we understand that - does this happen to you?**
Mark only one oval.

- ( ) Yes
- ( ) No

16. **How can we best help you if the above happens - what works best to help you calm yourself - what would you like us to do? when we notice that things are going wrong - how do we help you**

17. **Do you have any medications which we will need to administer? (please note must be in WEBSTER pack and authority signed before any shift)** *
Mark only one oval.

- ( ) Yes
- ( ) No

18. **Do you have any allergies** *
Check all that apply.

- [ ] Yes
- [ ] No

19. **If yes, please list allergies below and if you have an Anaphylaxis plan please attach.**
Mark only one oval.

- ( ) Attached
- ( ) Not applicable

20. **Do you have epilepsy?**
Mark only one oval.

- ( ) Yes
- ( ) No

21. **If YES to epilepsy please attach Epilepsy Plan**
Mark only one oval.

- ( ) Attached
- ( ) Not Applicable

22. **Do you have Asthma?** *
Mark only one oval.

- ( ) Yes
- ( ) No

23. **If YES, please attach Asthma plan**

Mark only one oval.

- ( ) attached
- ( ) Not applicable

24. **Community shifts - what would you like to do? Do you have a preference for who would be caring for you? ie. love markets, want to feel comfortable catching a train to Melbourne to see bands etc.**

25. **Community Shifts - when would you like to go out? please list days and times. (Please try to be specific ie. Tuesday - access community 10am to 4pm or Shopping Shift - Wednesdays 8am - 10:00am)**

26. **Personal Care - Please provide us details on what support you would like us to provide and how often ie.. morning support, assist with getting out of bed, assistance in the shower, make bed, assistance dressing, make breakfast,**

27. **Handyman and Gardening Support - Please detail the assistance you require and how often. If it is a large job which requires a big clean up please let me know below and we will provide you with a quote**

28. **We want to provide you with the best service and tailored to your needs - your our boss so please tell us anything below which you want us to know.**

29. **Your Name (if not participant)**

30. **Are you legal guardian or support Coordinator**
Mark only one oval.

- ( ) Legal Guardian
- ( ) Support Coordinator

31. **Your Phone Number** *

32. **Your email**

33. **Organisation**