FM-OPS-021
Supported Accommodation Intake Form

windgap FOUNDATION LIMITED

Photo

Personal Details

Name:	Date of Birth:
Gender ☐Male ■Female ☐Other	
Current Address:	
Phone Number:	
Email address:	
NDIS Number:	Medicare Number:
Pension Card:	Centre Link (CRN):

Heritage/Indigenous Status

☐Aboriginal	☐Torres Strait Islander	☐Other:
Is an interpreter required:		

Personal characteristics

Height: cm	Weight: kg	Date last weighed:
Eye Colour:	Hair Colour:	Complexion:
Distinguishing Features:		

Authorised Representative Details/legally appointed Guardian

Name:	Relationship:
Current Address:	
Phone Number:	Work number:
Email address:	

Name:	Relationship:
Current Address:	
Phone Number:	Work number:
Email address:	

Nature of Disability			
Intellectual	☐Low	☐Moderate	☐High
Developmental	☐Low	☐Moderate	☐High
Physical	☐Low	☐Moderate	☐High
Vision	☐Low	☐Moderate	☐High
Hearing	☐Low	☐Moderate	☐High
Speech	☐Low	☐Moderate	☐High
Neurological	☐Low	☐Moderate	☐High
Psychiatric	☐Low	☐Moderate	☐High
Speech Learning/ADD	☐Low	☐Moderate	☐High
Blind/ Deaf	☐Low	☐Moderate	☐High
Acquired Brain Injury	☐Low	☐Moderate	☐High
Autism/ Asperger's	☐Low	☐Moderate	☐High
Other Condition:			

Support needs			
Day time Please give details:	☐Low	☐Moderate	☐High
In the community Please give details:	☐Low	☐Moderate	☐High
During the night Please give details:	☐Low	☐Moderate	☐High
Personal Care Please give details:	☐Low	☐Moderate	☐High
Medication Please give details:	☐Low	☐Moderate	☐High

Do you suffer from:	
☐Epilepsy or seizures	☐Dementia
☐Disorientation	☐Memory problem
☐Headache	
Other:	

If Epileptic:			
Type of Seizure:			
Level of Control	☐Low	☐Moderate	☐High
Frequency of Seizure:			
Trigger for Seizure:			
Warning Signs:			
Length of Seizure:			
Treatment during Seizure:			
After Care:			
Epilepsy management plans?	☐Yes	☐No	Date of review:

Medication						
Name of medication	Dosage	Morning	Lunch	Night	PRN	Self Administered

Allergies		
Are there any allergies?	☐Yes	☐No
Allergen:		
Reaction:		
Treatment:		

Mobility:			
How is your mobility	☐Low	☐Moderate	☐High
How is your balance	☐Low	☐Moderate	☐High
Do you suffer from spasm's	☐Yes	☐No	
If yes please describe:			
Do you require any mobility aids?	☐Yes	☐No	
If yes please describe:			

Continence		
Do you require any continence aids?	☐Yes	☐No
If yes please describe frequency of use:		
How many pads per day?		
Do you suffer from pressure sores?	☐Yes	☐No

Behavioural Issues		
Do you have behaviors we should be aware of	**☐Yes**	**☐No**
Description of Behavior:		
Where do they occur?		
How often:		
How long:		
Triggers:		
Impact on self and others:		
Is there a program in place?		
How well is it working:		
Date of review:		

Psychiatrist	
Name:	
Current Address:	
Phone Number:	Work number:
Email address:	

Behavioural Consultant	
Name:	
Current Address:	
Phone Number:	Work number:
Email address:	

Doctor details	
General Practitioner	
Name:	
Current Address:	
Phone Number:	Work number:
Email address:	

Other Doctors	
Name:	
Current Address:	
Phone Number:	Work number:
Email address:	

Name:	
Current Address:	
Phone Number:	Work number:
Email address:	
Name:	
Current Address:	
Phone Number:	Work number:
Email address:	

Eating requirements and support

Are there dietary restrictions	☐Yes	☐No	
Is yes please describe:			
Has a Nutrition and Swallowing Checklist been completed?		☐Yes	☐No
Is yes what the results are:			
Level of assistance to eat	☐Total	☐Partial	☐None
If assistance is required please describe:			
Level of assistance to drink	☐Total	☐Partial	☐None
If assistance is required please describe:			

Funding

Do you currently have an NDIS plan?	☐Yes	☐No
If no please give details of funding:		
Do you currently have Accommodation funding?	☐Yes	☐No
Have you had an accommodation placement with Windgap or another provider in the last five years?	☐Yes	☐No
If yes: Who was the accommodation provider?		
What was your reason for leaving?		
Do you give consent for Windgap to contact that provider?	☐Yes	☐No

Accommodation

Accommodation Need:	☐Immediate	☐Wait until an appropriate vacancy
<u>If immediate please give details:</u>		
Please note although your need is immediate Windgap cannot guarantee a place.		

Please provide an overview of your Week:							
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Morning							
Afternoon							
Evening							

Do you attend day programs?	☐Yes	☐No
If yes who is your provider?		

If you have more than one provider can you please list them:
Provider:
Address:
Phone:
Email :

Provider:
Address:
Phone:
Email:

Provider:
Address:
Phone:
Email:

THE STORY OF ME

My name is: _____

THINGS THAT ARE IMPORTANT TO ME

1. _____
2. _____
3. _____
4. _____
5. _____

HOW YOU CAN HELP ME

1. _____
2. _____
3. _____
4. _____
5. _____

WHAT I LIKE

1. _____
2. _____
3. _____
4. _____
5. _____

THINGS THAT I AM GOOD AT

1. _____
2. _____
3. _____
4. _____

THINGS THAT I FIND HARD

1. _____
2. _____
3. _____
4. _____

Signoff

Participant Signature:_____

Authorised Representative Name_____

Authorised Representative Signature_____

Date: _____