

Intake Form – New Clients

Initial Needs Identification

BACKGROUND INFORMATION

Intake conducted by	Date
Type <input type="checkbox"/> Face-to-face <input type="checkbox"/> Telephone	
Verbal consent given by client <input type="checkbox"/> Yes <input type="checkbox"/> No	
How did the client find out about ADEC?	
<input type="checkbox"/> Word of mouth – other clients, family, community etc (<i>circle which</i>)	
<input type="checkbox"/> Social media – Facebook, ADEC website, Twitter etc (<i>circle which</i>)	
<input type="checkbox"/> Other organisations and service providers (<i>state which</i>)	
<input type="checkbox"/> Other (<i>specify</i>)	

CLIENT DETAILS

Eligibility for ADEC Services

Client eligible to receive ADEC services <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If No, re-direct to other provider or appropriate service</i>)
Client wishes to enter (<i>name of program</i>)
ATSI <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not wish to declare
If Yes, is this the <input type="checkbox"/> Carer <input type="checkbox"/> Person with disability or mental illness
If Yes, does client wish support to access ATSI services <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, refer to appropriate service (separate referral to Advocacy)

Referral Details

<input type="checkbox"/> Self-referral <input type="checkbox"/> External <input type="checkbox"/> Other type (<i>specify</i>)	
(<i>If External or Other type</i>)	
Name of agency	Contact person
Contact no	Position

Interpreters and Language

Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>language</i>)
If Yes, is the interpreter required for the <input type="checkbox"/> Carer <input type="checkbox"/> Person with disability
Gender of interpreter preferred <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference

NDIS/My Aged Care and DSR

Include the following information in internal referral to ADEC program and in Carelink+ intake case note.

Is client already registered on the DSR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
If No, does client wish to register	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
If Yes, is client receiving a package	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Is client eligible for NDIS/My Aged Care (<i>circle</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, is client registered with NDIS/MAC	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
If Yes, state NDIS/MAC number here if known			

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Is client receiving a support package	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
If Yes, enter plan date and end date if known			
If No, does client wish to apply for a package	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure

Personal Information

Information Required	Carer or Representative of PWD	PWD
Relationship	Of carer to PWD	Of PWD to carer
Consent to act	<input type="checkbox"/> Yes <input type="checkbox"/> No	
First name		
Last name		
Preferred name		
Address		
Region		
Date of birth		
Contact no		
Email		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Disability	<input type="checkbox"/> ABI <input type="checkbox"/> Autism <input type="checkbox"/> Intellectual <input type="checkbox"/> Physical <input type="checkbox"/> Psych <input type="checkbox"/> Sensory <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Specific Learning <input type="checkbox"/> Cognitive/Neurological	<input type="checkbox"/> ABI <input type="checkbox"/> Autism <input type="checkbox"/> Intellectual <input type="checkbox"/> Physical <input type="checkbox"/> Psych <input type="checkbox"/> Sensory <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Specific Learning <input type="checkbox"/> Cognitive/Neurological
Severity	<input type="checkbox"/> Medium <input type="checkbox"/> Mild <input type="checkbox"/> Severe	<input type="checkbox"/> Medium <input type="checkbox"/> Mild <input type="checkbox"/> Severe
Country of birth		
Ethnicity if different		
Language used at home		
Accommodation	<input type="checkbox"/> Owned <input type="checkbox"/> Rented <input type="checkbox"/> Supported accommodation <input type="checkbox"/> Other (<i>specify</i>)	<input type="checkbox"/> Owned <input type="checkbox"/> Rented <input type="checkbox"/> Same <input type="checkbox"/> Supported accommodation <input type="checkbox"/> Other (<i>specify</i>)
Australian citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No (If No, state immigration status)	<input type="checkbox"/> Yes <input type="checkbox"/> No (If No, state immigration status)
Source of income		
Medicare no		
Pension no (CRN)		

Emergency Contact

Name	Surname
Relationship	Contact number to call

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Risk Indicators

The indicators listed below should be included in the referral to program, to alert program staff to a potential security issue when making home visits, especially for the first time or to a new client.

- | | |
|--|--|
| <input type="checkbox"/> Animals in the home or on the premises | <input type="checkbox"/> Large/dangerous breed of dog? |
| <input type="checkbox"/> Are there any weapons in the house | |
| <input type="checkbox"/> History of dangerous behaviour <i>(may emerge during discussion of presenting issues)</i> | |
| <input type="checkbox"/> Episodes of family violence <i>(may emerge during discussion of presenting issues)</i> | |
| <input type="checkbox"/> Mental health issues or illness <i>(will have emerged during discussion of disabilities)</i> | |
| <input type="checkbox"/> Other family members in the home – might they present risk? <i>(should emerge during discussion of living conditions)</i> | |

Presenting Issues and Forthcoming Events

(eg. other supports received; other providers; marital status if relevant; how disability was acquired; was disability work related; what sort of assistance does the client need; living arrangements)

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MDS Activities Functional Assessment

Safety or risk issues, or particular strengths or needs of the carer or person with disability that are identified during the assessment should be reflected in the Goals and Actions to be Taken described in the CSP, and clearly explained to support workers.

Domestic Care

Function	Carer	PWD	Identified Safety or Risk Issue, Strength, or Need
Housework Can maintain house without help or support Need some help or supervision Completely unable to do housework	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Transport Without help With help (<i>needs some access to accompany</i>) Completely unable to travel	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Shopping (Assuming client has transport) Can take care of all shopping needs With help (<i>needs some access to accompany</i>) Completely unable to do any shopping	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Taking Medications If 'Yes' Without help (<i>right dose, right time</i>) With some help Completely unable to take medication without help	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Handling Money Without help With some help Completely unable to handle money	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mobility – Walking Without help except for use of cane With some help from a person or walker Completely unable to walk	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mobility – Bed/Chair Transfers No help needed Needs some help Unable to manage, no balance while sitting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

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Personal Care

Function	Carer	PWD	Identified Safety or Risk Issue, Strength, or Need
Does the client need assistance with any areas of personal care/self-care, such as bathing, dressing, eating, toileting, managing incontinence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bathing			
Without help	<input type="checkbox"/>	<input type="checkbox"/>	
With some help	<input type="checkbox"/>	<input type="checkbox"/>	
Completely unable to work without help	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing			
Without help	<input type="checkbox"/>	<input type="checkbox"/>	
With some help	<input type="checkbox"/>	<input type="checkbox"/>	
Completely unable to dress	<input type="checkbox"/>	<input type="checkbox"/>	
Eating			
Without help	<input type="checkbox"/>	<input type="checkbox"/>	
With some help	<input type="checkbox"/>	<input type="checkbox"/>	
Completely unable to eat without help	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet Use			
Without help	<input type="checkbox"/>	<input type="checkbox"/>	
With some help	<input type="checkbox"/>	<input type="checkbox"/>	
Completely unable to manage toilet without help	<input type="checkbox"/>	<input type="checkbox"/>	

Communication, Cognition and Behaviour

Function	Carer	PWD	Identified Safety or Risk Issue, Strength, or Need
Does the client need assistance with communication or making themselves understood by others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Communication			
No assistance required	<input type="checkbox"/>	<input type="checkbox"/>	
Some assistance required	<input type="checkbox"/>	<input type="checkbox"/>	
Assistance always required	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Problems or Concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Behavioural Problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	