1 TECH WAY
CRANBOURNE, 3977
1800 774 622
www.primacycare.com.au
ABN: 61 632 615 715 | ACN: 632 615 715

Primacy Care Australia – Intake Form

Please send the completed form to: referral@primacycare.com.au

PARTICIPANT DETAILS

First name	Last name
Date of birth	NDIS number
Preferred language	Cultural background / preference
Sex recorded at birth	Residential address
Gender identity	
Please share your pronoun	Suburb State Postcode
Contact number	Email

Living arrangement

Alone ☐ Family / Partner ☐ Supported accommodation ☐

Other (Please specify) ☐

PLAN MANAGER DETAILS

Name	Phone
Email	
Plan Start Date	Plan End Date

SUPPORT PERSON / EMERGENCY CONTACT DETAILS

Full Name	Phone
Relationship with Participant	Email

Role of support

☐ Nominee ☐ Main Contact ☐ Decision Maker ☐ Welfare Checks ☐ Emergency Only

REFERRER DETAILS

Full name	Phone
Relationship with Participant	Email

ADDITIONAL CONTACT INFORMATION

PRIMACY
MENTAL HEALTH SUPPORT PROVIDER CARE

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PARTICIPANT'S DISABILITY

Diagnosis

Additional Information

SUPPORT REQUIRED

Days | Set days ☐ Flexible ☐

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
☐ AM	☐ PM	☐ AM	☐ PM	☐ AM	☐ PM	☐ AM	☐ PM	☐ AM	☐ PM	☐ AM	☐ PM	☐ AM	☐ PM

Description of support required (e.g., hours, preference)

PUBLIC HOLIDAY SUPPORT FUNDING

Public holidays are regarded as additional support and charged at the applicable NDIS rate.
Please indicate the approval process ☐ Funding Available ☐ Not Available

Pre-approved ☐ Consult with referrer ☐ Consult with Participant ☐

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SAFETY SCREENING

This is a mandatory form which must be completed prior to any face-to-face visit

	Yes last 6mth's	Yes over 6mth's	No	Unknown
Any risk of self-harm identified	◯	◯	◯	◯
Any harm from others identified	◯	◯	◯	◯
Any harm to others identified	◯	◯	◯	◯
Hoarding concerns	◯	◯	◯	◯
Reports of property destruction	◯	◯	◯	◯
Reports of physical aggression	◯	◯	◯	◯
Reports of verbal aggression	◯	◯	◯	◯
Reports of absconding	◯	◯	◯	◯
Domestic violence concerns	◯	◯	◯	◯
Reports of inappropriate sexual behaviour	◯	◯	◯	◯

	Yes	No	Unknown
Is there a tobacco smoker at the property	◯	◯	◯
Are there recreational drugs at the property	◯	◯	◯
Are there concerns with alcohol consumption	◯	◯	◯
Are there firearms/weapons on the property	◯	◯	◯
Will anyone else be at the property during support	◯	◯	◯
Are there clear entry/exit points to the property	◯	◯	◯
Is there parking available at the property	◯	◯	◯
Are there pets on the property*	◯	◯	◯

*Dog ☐ Cat ☐ Bird ☐ Reptile ☐ Arachnid ☐ Other ☐

Pet information

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MEDICATION AND MEALTIME INFORMATION

Mealtime	Yes	No
When eating or drinking, do you ever have trouble swallowing?	◯	◯
Do you avoid any foods because they are hard to eat or give you any type of side effects?	◯	◯
Does it feel like food or drink gets stuck in your throat?	◯	◯
Do you ever regurgitate your food or drink?	◯	◯
Medication	**Yes**	**No**
Do you take medication?	◯	◯
Do you independently take medication?	◯	◯

ADDITIONAL PLANS

Are there any risk, behaviour, support, or medical plans in place that we should be aware of prior to attending the appointment, recent reports to be supplied

☐ BSP ☐ Interim BSP ☐ Medical Plan ☐ Risk Assessment ☐ Report being compiled

Additional Safety Concerns

HOW DID YOU HEAR ABOUT PRIMACY CARE AUSTRALIA?