Client Services Intake Form

CLIENT DETAILS		CLIENT PHOTO
Surname:	Given Name:	
Address:		
Suburb:	Postcode:	
Phone: (H)	(M)	
Email:	Date of Birth:	
Gender:	NDIS No:	
Primary Disability:		
Secondary Disability:		

EMERGENCY CONTACT PERSON DETAILS		
Surname:	Given Name:	Relationship:
Address:		
Phone: (H)	(M)	

WHAT TYPES OF SUPPORT WOULD YOU LIKE TO RECEIVE FROM SPECTRUM?

☐ Individual ☐ Group ☐ In-home ☐ Community Access ☐ Centre Based ☐ Holiday program

CLIENT HEALTH

Allergies:

MEDICAL CENTRE/DOCTOR DETAILS

Medical Centre: Doctor's Name:

Address:

Contact Number:

CLIENT MEDICATION SUMMARY

Please note that if assistance or supervision is required to manage medication in the course of service provision, a clarification of purpose of medication (COPOM) form will be required. This form must be less than 12months old, list all current medications in the correct doses and be signed by a medical practitioner. The COPOM form is available on our website or our service team will be happy to provide one on request. For assistance with medication identified as PRN administration, a protocol for administration, signed and dated by a medical practitioner, will be required in addition to the COPOM form.

☐ Clarification of Purpose of Medication (COPOM) form attached

☐ Medication not required to be administered be Spectrum Staff

Does your client suffer from seizures? ☐ Yes ☐ No

If yes, please provide a Seizure Management Plan

CLIENT CHARACTER TRAITS
Personality:
Strengths (ie; things your person is good at):
Fears:
Favourite Activities:
CLIENT BEHAVOUR
Provide details on any behaviours and how you would prefer staff to manage the behaviours:
Provide details for any triggers for behaviour/s (eg; changes to routine/activity, being touched, different staff etc):
CLIENT DIETARY REQUIREMENTS
Are there any special dietary requirements?
Any allergies or intolerances?
Require texture modified foods or fluids?
Any fluid restrictions?
Assistance with eating/cutting food? YES ☐ NO ☐

COMMUNICATION

Is the person verbal ☐ or non-verbal ☐

Provide details on how your person expresses themselves (eg: full sentences, sign language, simple words, use of any assistance devices).

Detail if staff are required to modify the way they communicate (eg: allow more time to answer, ask for eye contact):

CLIENT COMMUNITY ACCESS INFORMATION

Please provide details on the following:	Y	N	Details
Companion Card	☐	☐	
Taxi subsidy Card	☐	☐	
Capably with Money Handling	☐	☐	
Concerns in car	☐	☐	
Places to avoid	☐	☐	
Comfortable in crowds	☐	☐	

TOILETING

Client is continent ☐ or incontinent ☐

Please list what incontinent/toileting tasks are needed:

PERSONAL CARE

Is the client self-sufficient with:	Y	N	Details
Dressing	☐	☐	
Showering	☐	☐	
Oral Care	☐	☐	
Shaving	☐	☐	

CLIENT MOBILITY / MANUAL HANDLING

	Y	N	
Is the client mobile?	☐	☐	
Does the client require the use of a wheelchair?	☐	☐	
Does the client require the use of a booster seat?	☐	☐	
If yes, you will need to provide manual handling and/or transfer instructions/procedure to ensure safety with all transfers			
Is the client prone to falls?	☐	☐	

Please list any other equipment needed.

NO LIFT POLICY

The Spectrum Organization have a 'No Lift Policy", if transfers or the client's mobility decreases, the Guardian and/or NOK will be contact to discuss further. There may be occasions where staff will not be able to perform transfers until a safe option is available.

OTHER INFORMATION

Please provide any other information that you think might be relevant for support:

CONSENT:

I, (client/carer/legal guardian) give consent to The Spectrum Organization to release relevant information on this form onto a client profile that is to be given only to those staff who will support my child/adult.

Signed: Date:

Witness Sign: Date: