

Le Oasis Disability Services appreciates that everyone is unique, please help us to get to know you by answering the following:

Client Details	
Client First Name:	
Client Last Name:	
Client Date of Birth:	
NDIS Number:	
NDIS Funding Type:	<input type="checkbox"/> Agency Managed (NDIS) <input type="checkbox"/> Self Managed <input type="checkbox"/> Plan Managed
Provide Plan Manager (if applicable) see NDIS Funding Type	
Address	
Contact Number	
Email	
Preferred method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail

Representative or Emergency Contact Details	
First Name	
Last Name	
Relationship to Client	
Address	
Phone Number	
Email	
Preferred method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail

About the Client	
Living Situation	<input type="checkbox"/> Own home (alone) <input type="checkbox"/> Own Home (with family) <input type="checkbox"/> Supported Accommodation <input type="checkbox"/> Temporary <input type="checkbox"/> Other: _____
Aboriginal or Torres Strait Islander descent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Client have a current Behavioural Support Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Formal Diagnosis	
Secondary Formal Diagnosis	
Does the Client have any allergies? If yes please provide below	
Please provide all medical diagnosis and medicine that may affect the support provided	
Please provide the name and contact number for Client's Doctor	
Please disclose any legal issues that may affect service eg. Apprehended Violence Order	

Communication	
Type	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Communication aids required <input type="checkbox"/> Other: _____
Is the Client of a culturally or linguistically diverse background?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Languages Spoken	<input type="checkbox"/> English <input type="checkbox"/> Other: _____
Is an Interpreter required?	<input type="checkbox"/> No <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Language

Consent	
Does the Client consent to participating in and use of...	<input type="checkbox"/> Photos for Goal Data <input type="checkbox"/> Photos for Social Media <input type="checkbox"/> Photos for the website <input type="checkbox"/> None of the above

Dietary Requirements		
I have the following allergies/intolerances and my favourite food is...		
No dietary requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vegetarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vegan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am allergic to (please list)		







I am unable to eat (sensory/intolerances)	
My favourite food is...	
Le Oasis Disability Services can assist me during mealtimes by...	
<input type="checkbox"/>	I can identify what foods are safe for me to eat (if required due to allergy or dietary requirements).
<input type="checkbox"/>	If I have a food allergy, I have provided Le Oasis Disability Services with a management plan.
<input type="checkbox"/>	If required I will bring any medications to assist me with my allergy and have completed the relevant medical forms
<input type="checkbox"/>	I prefer to provide my own food and will do so

Mental Health			
I have/experience...			
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Psychosis	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	Other
I would like Le Oasis Disability Services to help me manage this by...			
My triggers may include...			
I am supported/linked with the following organisations who assist me... (Please supply relevant management plans.)			
<input type="checkbox"/>	I have received medical support to assist me and Le Oasis Disability Services has a copy of any relevant management plans to help me manage.		

Physical Health			
I have...			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sleep Apnoea
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Dietary Needs
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Hearing Impairment
<input type="checkbox"/>	Cognitive Impairment	<input type="checkbox"/>	Heart Conditions
<input type="checkbox"/>	Allergies to:		
<input type="checkbox"/>	Other:		
I would like Le Oasis Disability Services to help me manage this by...			
Please supply Le Oasis Disability Services with relevant management plans prior to commencing programs.			

Practical Support Needs			
Check the boxes which best represent you and your support needs...			
Behaviour	I can do independently	I need a little help	I cannot do independently
Traffic awareness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying with the group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating appropriately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking after property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being aware of personal space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping my hands to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Travelling safely in a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Following instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming and safety around water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can handle my own spending money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am comfortable in my sleeping routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Le Oasis Disability Services can assist me by...			
<input type="checkbox"/>	I have provided Le Oasis Disability Services with any relevant behaviour plans for assisting me when required.		

A bit about you and your goals		
To help us understand you better, please fill the below:		
	My strengths are (what I am good at)...	
	I like...	
	I don't like... (please include any sensory considerations)	
	You will know when I am happy by...	
	You will know when I am unhappy by...	
	I prefer to communicate by...	