Mercy Connect Intake Form

Part 1: Referral Information

Support Coordinators Details

Full Name		**Company**	
Contact Number		**Email**	

Plan Manager Details (If applicable)

Full Name		**Company**	
Contact Number		**Email**	

Primary Carer Information

Full Name		**Contact Number**	
Address			
Email			
Significant others *(e.g. Family members)*			

Services being requested

What service is being requested? *(Please Tick)*	**Accommodation** ☐	**Support Coordination** ☐	**Day Program** ☐	**Community Access** ☐	
	Daily Living ☐	**STA** ☐	**Personal Care** ☐	**Transport** ☐	**Improved relationship** ☐
Please provide a brief description of service being requested *(e.g time, dates, location)*			**NDIS Item Number**		

Consent

Is the participant their own consenter?	**Yes** ☐	**No** ☐	***If no please fill in the following**
Name of Legal Guardian			
NDIS Nominee Name			
Financial Guardian Name			
Date of orders:		**Date of consent to share information:**	
Email:		**Phone:**	

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Part 2: Participant Information

Full Name			
Middle Name			
Last Name			
Gender		**D.O.B**	
Contact Number			

Current Address					
Language Spoken			**Country of Birth**		
Aboriginal / Torres Strait Island	**Yes** ☐	**No** ☐	**Interpreter required?**	**Yes** ☐	**No** ☐
Medicare Number			**Expiry Date**		
Health Care Card Number			**Expiry Date**		
Pension Card Number			**Expiry Date**		
Companion Card Number			**Expiry Date**		

Part 3: Plan Details

NDIS Number			**Plan Managed**	**Yes** ☐	**No** ☐
Transport Required	**Yes** ☐	**No** ☐	**Self-Managed**	**Yes** ☐	**No** ☐
NDIS Plan Start Date			**NDIS Plan End Date**		
Has the participant got an approved NDIS plan for the requested service?	**Yes** ☐	**No** ☐	**What is the funded support ratio requested**	**1:1** ☐	**1:2** ☐
				1:3 ☐	**1:4** ☐
How long is the service required? (e.g. 2 *weeks, length of plan)*	***Only relevant for Short Term Accommodation***				
Is the participant currently accessing other providers for support?	***If yes, please outline current services i.e day programs mon-fri 9am-3pm***				

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Part 4: Care related Information – Please provide any supporting plans/information

Participants Diagnosis? *(brief list of participants diagnosed conditions.)*			
Participants interests and likes?			
Participant dislikes?			
Does the person need assistance to communicate?	**Yes** ☐	**No** ☐	**Please State:**
Are there any restrictive practices in place?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have significant health/ medical concerns?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have any mobility restrictions	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have any allergies?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant take regular medication?	**Yes** ☐	**No** ☐	**Please list:**
Does the participant have a mealtime management plan?	**Yes** ☐	**No** ☐	**Please provide & note IDDSI level:**
Does the participant have any therapeutic care plans?	**Yes** ☐	**No** ☐	**Please State:**
Are there any court orders in place?	**Yes** ☐	**No** ☐	**Please State:**
Are there any transport requirements?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have staffing preferences / requirements?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have specialised equipment needs?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have a history of Drug & Alcohol dependency?	**Yes** ☐	**No** ☐	**Please State:**
Does the participant have any behaviours of concern?	**Yes** ☐	**No** ☐	**Please State:**

Other Information

Does the participant have any additional care needs required whilst accessing services?

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Part 5: Supported Independent Living, STA and Drop-in supports

Support Needs Level of support required for daily living activities eg personal care	
Domestic Skills What level of support does the person required to undertake domestic duties such as cooking and cleaning?	
Finances Does the person require support to manage their finance? If so what type of support is required?	
Social Skills How does the person interact with others?	
Shared Living What attributes would best suit the participant when considering shared living arrangements?	
Environmental Factors Does the person need a quiet space, garden, private bathroom etc	
Personal Routines What does a regular day look like?	
Health/Medical Requirements Physical, mental &sexual health – include current medications, medical needs, GP and health supports/providers	
Diet and Eating Can the person independently consume food? Are there any special dietary requirements? **Please include any Nutrition and swallowing assessments**	
Cultural/Family/Social Networks Detail any social groups, classes or connections that are in the current community. Note any cultural connections	
Communication How does the person communicate? Please include any assessments	
Goals and dreams What is important to and for the person?	
My ideal life would be?	
Previous placements Details of previous placements	
Travel How does the person access the community eg can they use public transport or is a transport protocol in place?	
Other Any other important information to support the application	

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Part 6: Behaviour Support

What is the reason for your referral			
Please list the funding type for the supports requested	☐ **Line item 1: Specialist Behavioural Intervention Support (SBIS)** ☐ **Line item 2: Behaviour Management Plan including training (BMP)** ☐ **Line item 3: Individual Skill Development (SKD)**		
Please note any relevant information regarding the funding lines above			
Do you have a current Behaviour Support Plan?	**Yes** ☐	**No** ☐	**If yes, what is the start date of the plan?**
If yes: **Does the behaviour support plan contain any restricted practices?**	**Yes** ☐	**No** ☐	**Please State:**
Do you have any regular involvement with: • **Child Protection** • **Justice System** • **Mental Health**	**Yes** ☐	**No** ☐	**Please State:**
Please note any other relevant information			

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Part 7: Support Coordination Referrals

What is the number of Coordination of Support Hours in the plan?			
Do you need assistance with referrals?			
Supported Independent Living	**Yes** ☐	**No** ☐	**Please State:**
Allied Health	**Yes** ☐	**No** ☐	**Please State:**
Improved Relationships	**Yes** ☐	**No** ☐	**Please State:**
Other (please Specify)	**Yes** ☐	**No** ☐	**Please State:**
Please provide any other relevant information			