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Photo Permission: Date:

Support information

Emergency information							
Name:		**Gender:**		**Pronoun/s:**			
Address:				**Date of birth:**			
Participant phone number: (if applicable)				**Companion card:**			
Email address:				**NDIS Number:**			
Healthcare card number:				**Cultural background:**			
Medicare number:				**Interpreter required:**			
Religion:				**Language:**			
Name of Parents/Guardian:	**Relationship to participant:**	**Phone:**		**Mobile:**		**Work:**	

Emergency contacts				
Name:	**Relationship to participant:**	**Phone:**	**Mobile:**	**Work:**

Should a major incident occur, contact:			
A	**Relevant emergency services**	**Phone:**	**000 OR 112 (if out of mobile range)**
B		**Phone:**	
C		**Phone:**	
D		**Phone:**	

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Participant's medical records

Allergies: Please refer to EMP/s for further details.		**Medical conditions:** Please refer to EMP/s for further details.	
General Practitioner:		**Phone:**	
Medical specialist:		**Phone:**	
Private health fund/ Ambulance subscription:		**Preferred hospital:**	

Emergency information updated/checked by: Your Name Here **Date:**

Photo:

By signing this document, you acknowledge:

- The information within the support information document is correct.
- You understand that if there are any changes with the level of support required IOE needs to be notified and the support information updated.
- All updates will be sent to participants and or families to check and confirm that they are correct. IOE require the document to be signed, emailed or a letter stating that the updates have been checked and the document is correct.

Signature:	
Date:	

Information updated:		**Worker:**		**Who was consulted:**	

What do people like and admire about you

Social interactions

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Interests

Dislikes (Any fears or phobias?)

Family structure/living arrangements (Family pets?)

Name (incl. sibling D.O.B)	**Relationship**	**Address** (if not residing with the individual)	**Phone Number**

Cultural & Religious Practices

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Education / Vocation

Communication (What is your method of communication? Verbal – fluent in English, use single words, simple sentences, or short phrases? Non-Verbal – Sign Language, pictorial system, electronic devices, gestures, body language, communication book, vocalisations/sounds? Comprehension of verbal directions/instructions? How do you make choices? Literacy – can the person write, read?)

Mobility (Ability to walk, go up and down stairs, long distances? Stand unsupported, used wheelchair/walker?

Safety (Water, roads, hot things, public places, stranger danger, can you swim in pool/beach/dam? How do you respond in crowds? Ability to manage water temperature, can you be left alone for short periods of time at home or in public?

Food preferences and dietary requirements

Allergies/Restrictions	
Breakfast	
Lunch	
Dinner	
Snacks/Drinks	
Dislikes	

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Assistance with meals/drinks (Type of assistance (loading spoon, supporting elbows, full assistance)? What utensils are preferred, special equipment, left or right hand? Drinking - out of an open cup, spouted cup, use a straw? Ability to hold the cup and drink – without support, assistance with holding the cup/straw?) *If meals are taken via a gastrostomy tube, please complete the Tube feeding management plan.*

Sleeping (Ability to sleep a full night – requirements for complete darkness, night lights, closed/open door, favourite toys to take to bed, cd playing? Night routine, bedtime, and wake time in the morning? If you wake in the middle of the night, how should I respond?

Assistance and support required with personal care

Toilet routine (Independent, nappies, continence aids, toilet training, menstruation, assistance required, prompted to go to the toilet, assistance with wiping?)

Showering/bathing (Preference for shower or bath, independent with bathing, assistance required – full assistance, prompting, hair washing adjusting water temperature. Drying, tooth brushing, shaving?)

Dressing (Independent, assistance required – full assistance, picking weather appropriate clothes, buttons, shoelaces? Ability to choose clothes for the day?)

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Diagnosis of disability (Hearing Impairment, vision, mental health disorders)

Medical conditions or needs An emergency management plan needs to be developed and attached to the end of this document for the following areas: allergies, asthma, diabetes, epilepsy, gastrostomy tube feeding, medical condition

Aids & equipment

Type/Description	Instructions/Precautions

Sensory needs (auditory, tactile (touch, pressure), proprioception (sensation from muscles/joints), vestibular (movement), visual, olfactory (smell), taste.

Any other information (Time away from family, can you manage your own money, can you have alcohol, and how much can, or should you drink? Inappropriate sexualised behaviours/public masturbation?)

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What is the persons NDIS goals? (Please refer to NDIS plan)

What type of people are best suited to support the participant?

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Medication Sheet Before giving medication, check right person, right medication, right dosage, right time, and right route.	**Restrictive?** ☐ **YES** ☐ **NO**

Participant's name:		**Date of Birth:**		**Updated when and by:**	

How to administer medication: *Crushed, mixed with water, placed in food, self-administering, etc.*		**Allergies:**	

Signature: *Parent/guardian to sign to confirm medication list is correct*		**Date:**	

***Note**: List medications in order of the time given. That is, all morning medications first then lunchtime then dinner, and so on.*

Time to be administered	**Medication and strength** *Name of medication and strength per ONE tablet E.g., Lovan 10mg*	**Dosage** *how many mg/ml to be given & what this equal to in tablets E.g., 20mg (2 Tabs)*	**Method** *Oral* *Via PEG* *Injection*	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___
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Time to be administered	**Medication and strength** *Name of medication and strength per ONE tablet E.g., Lovan 10mg*	**Dosage** *how many mg/ml to be given & what this equal to in tablets E.g., 20mg (2 Tabs)*	**Method** *Oral Via PEG Injection*	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___	**Date:** ___/___/___
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Note: Please return medication sheets to Interchange Outer East by the 1st of each month.

People administering medication					
Print name	**Initial**	**Print name**	**Initial**	**Print name**	**Initial**

Please check that the information on this form corresponds with what medication that is being administered. If there are any discrepancies, please call the person's parents/carer to confirm. PRN Medication (i.e., "as needed" medication e.g., Panadol) can only be administered when detailed instructions from the parent/carer or IOE is provided. Approval from IOE Coordinators is required when administering PRN medication. When PRN medication (behaviour changing only) is administered an incident report is required by the following day.

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Appointments	
Date & Time	**Details & Instructions**
dd/mm/yyyy 00:00	**Name:** Here **Address:** Here
dd/mm/yyyy 00:00	**Name:** Here **Address:** Here

Activities	
Date & Time	**Details & Instructions**
dd/mm/yyyy 00:00	**Name:** Here **Address:** Here
dd/mm/yyyy 00:00	**Name:** Here **Address:** Here

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Roster information

(INTERNAL INFORMATION ONLY)

Property				Support Workers		Vehicles	
Respite Address				Gender		Car Allocated	
Pickup Address		Date		Ethnicity		Wheelchair Accessible	
Dropoff Address		Date		Language		Fuel Type	
Door/Key Code & Instructions				Training		Allocated KMs	

Staff Expenses		Participant Specific Requests (if applicable)	
Mileage Claim		Staff Pref	

Shift Instructions

PO Box 2007, Ocean Grove, VIC, 3226 | 0403 515 605 | ndis@destinationaccessible.com.au

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Shift Legend	Public Holiday (PH)

Shift Hours							
Date	Morning	Carers Required	Afternoon	Carers Required	Evening	Carers Required	Sleepover

PO Box 2007, Ocean Grove, VIC, 3226 0403 515 605 ndis@destinationaccessible.com.au