Clear Sky Australia - New Client Entry and Referral Form

Please complete the following form with as much information about you! Once you have completed the form one of CSA's representatives will be in touch with your preferred method of communication.

*Required

1. Name of person completing this form:

_____

2. Please tick one of the following in regards to who is completing this form:

Mark only one oval.

- ◯ I am completing it for myself
- ◯ I am Family Member
- ◯ I am a Friend
- ◯ I am a Coordinator of Support
- ◯ I am a Case Worker
- ◯ Other: _____

3. Date:

_____

Example: 7 January 2019

Communication Information

If you are completing this form on the behalf of someone else please put in their information in this section

4. Preferred Communication Method:

Mark only one oval.

- Email
- Phone Call
- Text
- Video Call
- Other: _____

5. Do you require an interpreter?:

Mark only one oval.

- Yes
- No
- Maybe
- Other: _____

Contact Details

If you are completing this form on the behalf of someone else please put in their information in this section

6. First Name:

_____

7. Surname:

_____

8. Preferred Name:

_____

9. Date of Birth:

_____

Example: 7 January 2019

10. Address:

_____

_____

_____

_____

_____

11. Home Phone Number:

_____

12. Mobile Phone Number:

_____

13. Email Address:

_____

On completion of this form please upload a nice photo of you so we can add it to your Personal CSA Profile Page

Personal Details

If you are completing this form on the behalf of someone else please put in their information in this section

14. Do you identify as Aboriginal or Torres Strait Islander?:

Mark only one oval.

- Yes
- No

15. Country of Birth:

_____

16. Ethnicity:

_____

17. Language spoken at home:

_____

18. Religion:

_____

19. About me:

Tell us a bit about you and your hobbies, interests and how best you like to be supported

_____

_____

_____

_____

_____

Disability

If you are completing this form on the behalf of someone else please put in their information in this section

20. Please tick any of the following Disabilities

Tick all that apply.

- [ ] Acquired Brain Injury
- [ ] Asperger's Syndrome
- [ ] Autism
- [ ] Blind/Vision Impairment
- [ ] Cerebral Palsy
- [ ] Deafblind
- [ ] Deaf/Hearing Impairment
- [ ] Epilepsy
- [ ] Huntington's Disease
- [ ] Intellectual Disability - Development (0-5)
- [ ] Intellectual Disability (Including Down Syndrome)
- [ ] Motor Neurone Disease
- [ ] Multiple Sclerosis
- [ ] Muscular Dystrophy
- [ ] Non/Verbal Speech Impairment
- [ ] Para/Quadri/Tetra Hemiplegia
- [ ] Pervasive Development Disorder
- [ ] Psychiatric
- [ ] Specific Learning Difficulty (including Attention Deficit Disorder and Dyslexia)

Other: ☐ _____

NDIS Details

If you are completing this form on the behalf of someone else please put in their information in this section

21. Plan Start Date:

_____

Example: 7 January 2019

22. Plan End Date:

Example: 7 January 2019

23. NDIS Number:

24. Plan Management:

Mark only one oval.

- Agency Managed
- Plan Managed
- Self-Managed

My NDIS Goals

You can find your NDIS goals inside the goal section of your NDIS Plan.

25. Goal 1:

26. Goal 2:

27. Goal 3:

28. Goal 4:

_____

What Support Items will you be bringing to Clear Sky Australia

Please select from the following options

29. CORE

Tick all that apply.

- [ ] Daily Living - Assistance with Daily Life / Supported Independent Living
- [ ] Daily Living - Transport
- [ ] Daily Living - Consumables
- [ ] Social & Community Participation – Assistance with Social & Community Participation

30. CAPACITY BUILDING

Tick all that apply.

- [ ] Choice & Control – Support Coordination
- [ ] Home – Improved Living Arrangements
- [ ] Increased Social & Community Participation
- [ ] Finding and Keeping a Job
- [ ] Improved Relationships
- [ ] Improved Health and Well-being
- [ ] Improved Learning
- [ ] Improved Life Choices
- [ ] Improved Daily Living Skills

Once you have complete this form please email a copy of your current or most recent NDIS Plan or Page/s relevant to your chosen budget to admin@clearskyaustralia.com.au

Emergency Contact

In case of an emergency please complete this section to ensure we have the right person/s to contact

Emergency Contact 1

31. Contact 1 Name:

_____

32. Contact 1 Address:

_____

33. Contact 1 Home Phone:

_____

34. Contact 1 Mobile Phone:

_____

35. Contact 1 Email:

_____

36. Contact 1 Relationship:

_____

Emergency Contact 2

37. Contact 2 Name:

_____

38. Contact 2 Address:

_____

39. Contact 2 Home Phone:

_____

40. Contact 2 Mobile Phone:

_____

41. Contact 2 Email:

_____

42. Contact 2 Relationship:

_____

Where do you live?

Please answer the following questions about your current living situations

43. Do you live in Supported Independent Living (SIL)?

Mark only one oval.

- Yes *Skip to question 44*
- No *Skip to question 50*

Supported Independent Living (SIL) Contact Information

Please provide information about your Supported Independent Living (SIL)

44. What are your living arrangements?:

Mark only one oval.

- Rent
- Own
- Board
- Other: _____

45. Type of accommodation:

_____

46. SIL Contact Name:

_____

47. SIL Contact Number:

_____

48. SIL Contact Email:

_____

49. SIL Contact Address:

_____

Other Supports

Please provide information on what other support services you may use

50. Do you have a caseworker/coordination of supports?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

51. Support Service/Company Name:

_____

52. Support Service/Contact Name:

_____

53. Support Service/Contact Number:

_____

54. Support Service/Contact Address:

_____

Communicating with others

Please provide information around preferred communication methods and strategies

55. Description of how you communicate with others:

56. How do people know if you are: happy, sad, angry, sick, in pain, content, anxious/scared/nervous, confused?

57. What things do you enjoy communicating about?

58. What are the best ways to help you to understand what others are ‘saying’ to you?

59. What are the best ways to help you to meet new people at home or in your community?

Medical Needs

Please list all the information in regards to any special medical needs you may have

60. GP Name:

61. GP Address:

62. GP Phone Number:

63. GP Email:

64. Do you have any special medical needs?

Mark only one oval.

- ◯ Yes *Skip to question 65*
- ◯ No *Skip to question 71*

Medical Needs Information

Please list all the information in regards to any special medical needs you may have

65. Details of provided medical needs:

_____

_____

_____

_____

_____

66. Do you require medication?

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

67. Can you take medication independently?

Mark only one oval.

- Yes
- No
- Other: _____

68. List of medications you take:

_____

_____

_____

_____

_____

69. Do you require PRN medication?

Medication that is taken “as needed” are known as “PRN” medicines.

Mark only one oval.

- Yes
- No
- Other: _____

70. Summary of PRN medication:

Medication that is taken “as needed” are known as “PRN” medicines.

_____

_____

_____

_____

_____

***Please be aware that we require a GP summary of your medication before any services can commence**

Allergies

Please list all information to any allergies you may have

71. Do you have any Allergies?:

Mark only one oval.

- Yes *Skip to question 72*
- No *Skip to question 81*

Please list your Allergies

Please list all information to any allergies you may have

Primary Allergy

72. Description of primary allergy

73. Description of trigger for primary allergy:

74. Description of reaction for primary allergy:

75. Description of management of primary allergy:

Secondary Allergy

76. Do you have a secondary allergy?

Mark only one oval.

- Yes
- No

77. Description of secondary allergy:

78. Description of trigger for secondary allergy:

79. Description of reaction for secondary allergy:

80. Description of management of secondary allergy:

Dietary Needs

Please list information in regards to any dietary needs you require

81. Do you have any specific dietary needs?

82. Are you allergic to any foods?

83. Is there any food you do not like?

Behaviour

Please list information in regards to any specific behaviours

84. Do you have any Specific behaviours that the CSA needs to know about:

Mark only one oval.

- Yes *Skip to question 85*
- No *Skip to question 93*

Behaviour Information

Please list information in regards to any specific behaviours

85. Specific behaviours that the service provider needs to know about:

86. Indicated behaviours that apply to them:

87. Details of behaviour:

88. Therapy services:

89. Behavioural Concerns:

90. Do they have a current behaviour plan?

Mark only one oval.

- Yes
- No
- Maybe

91. Do you have a psychologist?

Mark only one oval.

- Yes
- No
- Maybe

92. Details of psychologist:

Mobility

Please list any mobility needs that you may require

93. Please list any Mobility Needs:

94. Please list further details of these Mobility Needs:

Therapy Services

Please list any other therapy service that you use – These may include OT services

95. Name of Service 1:

96. Contact Details of Service 1:

97. Name of Service 2:

98. Contact Details of Service 2:

Environmental and Social Risks

Please provide any information around some of these environmental and social risks.

99. Water/Pools/Oceans:

100. Electricity:

101. Sharp Items:

102. Sun Exposure:

103. Flammables:

104. Traffic/Road Safety:

105. Stranger Danger:

106. Alcohol/Drugs:

Documents Checklist

Once you have completed this form, Please email the following document/s to admin@clearskyaustralia.com.au

107. Profile Photo of you (SMILE!): *

Tick all that apply.

- [ ] Ready to Upload

108. NDIS Plan or Budget Pages: *

Tick all that apply.

- [ ] Ready to Upload

109. Any clinical documentation or reports: *

Tick all that apply.

- [ ] Ready to Upload
- [ ] Does not apply

110. Deceleration:

By ticking this box I agree that all the information I have provided in this form is to the best of my knowledge and in the best interest of my support needs

Tick all that apply.

- [ ] Complete