SMM

SUPPORT
COORDINATION

SMM Support Coordination Intake / Referral Form

Participant Details

First name	
Last name	
Support Requested	☐ NDIS Participant ☐ Aged Care Participant
NDIS / AC Reference No.	
Address	
Phone number	
Email address	
Plan start date	
Plan end date	
Date of birth	
The participants preferred method of communication is Choose an item.	
Gender	☐ Male ☐ Female ☐ Other
Does the participant identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No ☐ Prefer not to answer	
Does the participant identify within the LGBTQI community? ☐ Yes ☐ No ☐ Prefer not to answer	
If on NDIS, plan funding is ☐ NDIS managed ☐ Self-managed ☐ Plan managed	

Emergency Contact

Name	
Relationship	
Address	

Phone number	
Email address	

Participant Information

What is the participants primary disability?	
Does the participant have a secondary disability?	☐ Yes ☐ No
Does the participant require culturally appropriate information?	☐ Yes ☐ No
Previous & current services	
Details of any medications	
Does the participant have any allergies?	☐ Yes ☐ No
Does the participant have a pre-existing health condition?	☐ Yes ☐ No
Please list any dietary requirements	

General Practitioner Details

Name of GP	
GP Phone Number	
GP Address	

Public Guardian / Financial Trustee / Enduring Power of Attorney

Does the participant have a Public Guardian or Financial Trustee or EPOA	☐ Yes ☐ No
If yes, which of the above is applicable	
Name	
Postal Address	
Email address	
Phone number	
If you do not have a Representative, would you like assistance or information pertaining to this	☐ Yes ☐ No

Participant

Introduction to the participant

Goals or Requirements

Other information