

Participant Intake Form

You can type directly into this form - no printing needed

Helpful to know

Fields marked * are important. A participant, family member or representative can complete this form.

1. About the participant

Full legal name *

Preferred name

Date of birth (DD/MM/YYYY) *

NDIS number

Pronouns (optional)

Participant phone

Participant email

Home address

2. Person completing this form

☐ Participant

☐ Parent / carer

☐ Other representative

Your name *

Relationship to participant

Best phone number *

Email address *

Contacts and NDIS plan

Tell us who to contact and how the participant's plan is managed

3. Emergency contact

Contact name *

Relationship to participant *

Phone number *

Alternative phone

4. NDIS plan details

If you do not know an answer, leave it blank and our team can help.

Plan start date (DD/MM/YYYY)

Plan end date (DD/MM/YYYY)

How is the plan managed?

☐ NDIA managed ☐ Plan managed ☐ Self-managed ☐ Unsure

Plan manager name (if applicable)

Plan manager phone

Plan manager email

Support coordinator name

Support coordinator phone

Support coordinator email

Can Sparks contact your plan manager/support coordinator about these services?

☐ Yes ☐ No

5. Supports requested

Tick all that apply.

- | | |
|---|---|
| ☐ Group programs | ☐ Community participation |
| ☐ One-to-one support | ☐ Transport / pick-up / drop-off |
| ☐ In-home support | ☐ School holiday programs |
| ☐ Personal care | ☐ Other / unsure |

If other, please tell us what support is needed

Preferred days and times

6. Goals and what matters

What would the participant like to learn, improve or enjoy? *

Interests, strengths and favourite activities

Things they dislike, avoid or find upsetting

7. Communication and daily support

How does the participant communicate? Tick all that apply.

- | | | |
|---|---|---|
| ☐ Speech | ☐ Gestures / body language | ☐ Pictures / visual supports |
| ☐ Communication device | ☐ Sign language | ☐ Other |

What helps the participant understand, make choices or feel comfortable?

Cultural, language, gender, faith or personal preferences

8. Health and support needs

Write 'none' if a question does not apply.

Disability, diagnoses or medical conditions *

Allergies

Medications staff need to know about

Mobility, eating, toileting, personal care or equipment needs

Health plans or emergency instructions (e.g. asthma, epilepsy, diabetes, PEG)

9. Risk and safety information

Behaviours, triggers or risks staff need to know about *

What helps prevent or respond to these situations?

Safety considerations at home, during transport or in the community

10. Consent and electronic submission

I confirm the information in this form is accurate to the best of my knowledge.

I consent to Sparks Social Abilities collecting and using this information to assess, plan and deliver supports.

I understand Sparks may contact me to clarify information or discuss whether the service can safely meet the participant's needs.

☐ I agree to the consent statement above *

Type your full name (electronic signature) *

Date (DD/MM/YYYY) *

Anything else you would like Sparks to know?

Before sending

Save a copy of the completed PDF, then return it to Sparks Social Abilities using the agreed secure method.

If you need help completing this form, contact the Sparks team.