NDIS Support Plan

Support Information

Support Plan Start Date ______________________ Support Plan Review Date ___________________

Support ____

Description

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How the support will be provided

____

____

____

Participant Details

First Name ___________________ Surname ___________________________ D.O.B _______________

Gender

☐ Male ☐ Female ☐ Other

Aboriginal or Torres Strait Islander

☐ No ☐ Yes, Aboriginal

☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal & Torres Strait Islander

Cultural Background ____

Preferred Language ____

Interpreter Required?

☐ Yes ☐ No

Financial Management Arrangements ____

Privacy Preferences ____

Participant Contact Information

Address ____

Email ____

Mobile ______________________________

Emergency Information

Name ____

Relationship ____

Address ____

Email ____

Mobile ______________________________

Does this participant require assistance in an emergency?

☐ Yes ☐ No

If yes, please provide details

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____

Does this participant have a personal emergency alarm?

☐ Yes ☐ No

Details of personal emergency device

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Emergency Management Arrangements

The participant is educated about the possibility of safety drills and knows that to do in these situations ☐

The participant and family/caregivers know where to gather in case of evacuation or separation during an emergency ☐

The participant will reunite their parents, guardians, or caregivers during an emergency:

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The participant and family can access mental health supports and counselling services to help them cope with the emotional impact of emergencies through their GP.

Due to the participant's special needs, the following specific accommodations and support need to be put in place:

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The participant and family know that regular emergency drills may be conducted at the clinic to reinforce emergency procedures and familiarize young people with the necessary actions. ☐

GP Information

Doctor's Name ____

Practice ____

Address ____

Email ____________________ Phone ____________________

Pharmacist Details

Pharmacist's Name ____

Practice ____

Email ____________________ Phone ____________________

Medication

Medication required

☐ Yes ☐ No

Prompt required

☐ Yes ☐ No

Assistance required

☐ Yes ☐ No

Administration required

☐ Yes ☐ No

Please give details

____

____

____

____

Decision Making

Please specify all people assisting the participant with decision making

Name ____

Relationship ____

Address ____

Email ____

Mobile ________________________________

Health and Medical

Allergies

____

____

____

____

Diagnosis, Disability or Medical Conditions

____

____

____

____

Medication Details

Medication required

☐ Yes ☐ No

Assistance and administration required

☐ Yes ☐ No

Details of medication

Diagnosis, Disability or Medical Conditions

Describe any health issues the participant may have, including mental health issues

Mental Health Care Plan

☐ Yes ☐ No

Is the participant currently receiving end of life care?

☐ Yes ☐ No

DNR order in place?

☐ Yes ☐ No

Preventative health measures

If support is required by the participant, what arrangements are in place to proactively support the participant with preventative health measures, including helping them to access recommended vaccinations, dental check-ups, comprehensive health assessments, and allied health services?

Preventative health measures

Where health needs are identified, what is the agreed process that needs to be followed to escalate and respond to medical emergencies?

Disability

Mobility

- ☐ Needs assistance
- ☐ Does not need assistance
- ☐ Is independent
- ☐ Is not independent

Hearing

- ☐ Nil issues
- ☐ Some issues
- ☐ Hearing impaired

Vision

- ☐ Nil issues
- ☐ Some issues
- ☐ Hearing impaired

Memory/Cognition

- ☐ Nil issues
- ☐ Some issues
- ☐ Cognitively impaired

Communication

- ☐ Does not need assistance
- ☐ Needs assistance

How does the participant prefer to communicate?

- ☐ Verbally
- ☐ Non verbally
- ☐ Sign
- ☐ Auslan
- ☐ Makaton
- ☐ Key Word Sign
- ☐ Point/gesture
- ☐ Alternative & Augmentative Communication (AAC)

Details

Continence

☐ Needs assistance ☐ Does not need assistance

Daily Living Supports

Showering/bathing

☐ No help ☐ Aids used ☐ Prompting required
☐ Some support ☐ Full support required

Details

____
____
____
____

Grooming

☐ No help ☐ Aids used ☐ Prompting required
☐ Some support ☐ Full support required

Details

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Dressing

☐ No help ☐ Aids used ☐ Prompting required
☐ Some support ☐ Full support required

Details

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Toileting

☐ No help ☐ Aids used ☐ Prompting required
☐ Some support ☐ Full support required

Details

Eating

☐ No help ☐ Aids used ☐ Prompting required

☐ Some support ☐ Full support required

Details

Transfers/Mobility

☐ No help ☐ Aids used ☐ Prompting required

☐ Some support ☐ Full support required

Details

Day and Night Supports

How often does the participant require supports throughout the day?

☐ None ☐ All ☐ During active times

Details

How often does the participant require supports throughout the day?

☐ None ☐ All ☐ During active times

Details

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____

Participant's Behaviour Supports

Does the participant have a current behaviour support plan?

☐ Yes ☐ No

Does the participant require a Functional Behaviour Assessment or Restrictive Practice Behaviour Support Plan regarding behaviours of concern?

☐ Yes ☐ No

Does the participant display or engage in any behaviours of concern that require specific support?

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____

Does the participant have a current risk assessment relating to their behaviour or support needs?

☐ Yes ☐ No

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Community Participation Supports

Does the participant need assistance getting round the community?

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What type of transport does the participant mainly use?

Does the participant need assistance to use transport?

Does the participant engage or participate in any recreational, community based, employment or training activities?

Does the participant need assistance to access any of these activities?

Risk Assessment

Risk description

Risk level

Action

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Service Provision

Participant's NDIS goals

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Personal preferences

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Goals for supports

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Supports provided

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Support plan agreement

I undersigned, agree with the following statements

☐ I agree that I have been involved in the development of my plan of care, my goals and the services required.

☐ I agree that I have given permission for my Support Plan to be distributed only to the people involved in the development and support of my care including nominated advocates/representatives and may be included in any referrals made on my behalf

Signed by participant ____

Date ____________________________