Cerebral Palsy ALLIANCE

Client Services Request

NS5-1-F1 – v2.1 – 05/09/23

Date:

Reason for Referral/Services needed

Where did you hear about this CPA product/ service?

Client Contact Details

First name:		Surname:		DOB:	
Address:		Suburb:		Postcode:	
Email:		Home phone:		Mobile:	
Housing type:	☐ Private home ☐ Specialist Disability Accommodation		☐ Public or community housing ☐ Other, please specify		
Language spoken at home:		Interpreter required? If yes, what type:		Aboriginal or Torres Strait Islander?	☐ Yes / ☐ No
Best time to contact (weekdays):	Time from:		Time to:		
Primary diagnosis/ disability:			Secondary diagnosis/ disability:		

Emergency Contact		**Support Coordinator Contact (if applicable)**	
First name:		First name:	
Surname:		Surname:	
Relationship to client:		Relationship to client:	
Street address:		Street address:	
Suburb:		Suburb:	
Postcode:		Postcode:	
Postal address:		Postal address:	
Home phone:		Home phone:	
Mobile:		Mobile:	
Email:		Email:	

Referrer Details (if not the client)		Primary Contact (if not Referrer)	
First name:		First name:	
Surname:		Surname:	
Relationship to client:		Relationship to client:	
Street address:		Street address:	
Suburb:		Suburb:	
Postcode:		Postcode:	
Postal address:		Postal address:	
Home phone:		Home phone:	
Mobile:		Mobile:	
Email:		Email:	

Client's current functional abilities (as needed)

Skill area	Developmentally age appropriate	Completely independent	Needs some help	Needs full assistance	Current needs/ priorities/ comments
Speech/ Communication *How do you/ your family member communicate (i.e. Verbal/ Non-verbal)?* *If non-verbal, what is the method used (e.g. signing/ pictures/ speech generating device/ symbol book)?* *What difficulties are you experiencing in relation to how you/ your family member communicates?* *What are you hoping to achieve by seeing the Speech Pathologist?* *If seeking Accommodation/ SIL services:* *- Staff training will be required – is there funding for this in the NDIS plan?* *- Do you/ your family member have a current Mealtime Management Plan?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
Vision/Hearing *Do you/ your family member have any difficulties with hearing or vision?* *(e.g. hearing aids/ cochlear implant/ glasses)* *For SIL services:* *Do you/ your family member have a Communication Plan, or will this need to be developed by a therapist?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
	Hearing impairment? ☐ Yes / ☐ No If yes, please describe: Vision impairment? ☐ Yes / ☐ No If yes, please describe:				

Skill area	Developmentally age appropriate	Completely independent	Needs some help	Needs full assistance	Current needs/ priorities/ comments
Daily Living Skills *Do you/ your family member have any difficulties or need assistance with daily living activities (e.g. cooking, cleaning, driving, shopping, money, phone, etc)?* *What do you hope to achieve by seeing the Occupational Therapist?* *For SIL services: What level of day-to-day support do you/ your family member require?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
Personal Self-Care *Do you/your family member have any difficulties with attending to your personal care (e.g. toileting, bathing, dressing, personal grooming etc)?* *What do you hope to achieve by seeing the Occupational Therapist?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
Learning/Cognitive Development *Do you/your family member have any difficulties with learning?* *(e.g. learning difficulties, academic or school related difficulties such as reading or maths, understanding instructions, remembering things)*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
Social, Recreational and Community Participation (including sports) *Do you/ your family member attend any programs in a centre or in the community? If so, what are they, and what are some of the activities?* *What are your/ your family member's hobbies/ interests? What do you/they dislike doing?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	

Skill area	Developmentally age appropriate	Completely independent	Needs some help	Needs full assistance	Current needs/ priorities/ comments
Mealtimes, Eating, Drinking and Swallowing *Do you/ your family member experience difficulties or have any concerns around mealtimes or with eating, drinking or swallowing?* *What are your concerns?* *Can you describe the difficulties?* *(e.g. pain/discomfort, distress, strong like/dislike of certain foods, coughing, mealtimes taking over 30 mins, history of chest infections)*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
	Eating, drinking, swallowing or choking difficulties ☐ Yes / ☐ No If yes, please describe issues or concerns: Is the client going to be accessing a service where they will need to be assisted with eating or drinking? ☐ Yes / ☐ No If yes, please describe the assistance required: Does the client need to use thickened drinks or modified meals? ☐ Yes / ☐ No / ☐ N/A If yes, please describe: Does the client have a current written Mealtime Plan? ☐ Yes / ☐ No If yes, please provide a copy.				
Physical wellbeing, development, mobility *What difficulties are you/ your family member experiencing in how you/they move, or physical health and wellbeing (e.g. posture, mobility, pain/ discomfort, hip health, surgery, fitness, weight gain or other health issues)?* *What are you hoping to achieve by seeing the Physiotherapist/ Occupational Therapist/ Exercise Physiologist?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
	Mobility support/ manual handling assistance required? ☐ Yes / ☐ No If yes, describe mobility assistance required: Usual transfer method: ☐ Hoist / ☐ Standing / ☐ Lift ☐ One carer / ☐ Two carers Alternate transfer methods: ☐ Hoist / ☐ Standing / ☐ Lift ☐ One carer / ☐ Two carers Does the client own their own sling/transfer belt? ☐ Yes / ☐ No If yes, please describe: Does the client have a current written Manual Handling Plan? ☐ Yes / ☐ No If yes, please provide a copy. Does the client have any relevant medical reports (from the last 5 years), such as hip x-rays or surgical reports, that have not previously been provided? ☐ Yes / ☐ No If yes, please provide a copy.				

<table>
<tr><th>Skill area</th><th>Developmentally age appropriate</th><th>Completely independent</th><th>Needs some help</th><th>Needs full assistance</th><th>Current needs/ priorities/ comments</th></tr>
<tr><td>Social, emotional, behavioural wellbeing

Do you/ your family member experience any difficulties or need assistance with your/ their emotional wellbeing or behaviour?

How do you/ your family member relate with friends? How do you/ they feel about yourself/ themselves?

What are you hoping to achieve by seeing the Psychologist/ Behaviour Support Practitioner/ Youth Coach?

What sort of things or circumstances upset you/ your family member, or make you/ them agitated or anxious?

(e.g. relationships, friends outside family, getting on with others, coping with stressful situations or life events, self-esteem, anxiety, or other mental health needs or behaviours of concern)</td><td>☐ Developmentally age appropriate</td><td>☐ Completely independent</td><td>☐ Needs some help</td><td>☐ Needs full assistance</td><td rowspan="2"></td></tr>
<tr><td colspan="4">Does the client have difficulties with managing their behaviour?
☐ Yes / ☐ No
If yes, please describe:

Does the client have a current written Behaviour Support Plan or Mental Health Care Plan?
☐ Yes / ☐ No
If yes, please provide a copy.

Does the client need or currently access supports for mental health, emotional wellbeing or behaviours of concern?
☐ Yes / ☐ No
If yes, please describe (include any therapies, interventions or specialists):</td></tr>
<tr><td>Health/ medical care support needs

Do you have any health care or medical care needs that are important for us to be aware of (e.g. epilepsy, chest infections, diabetes, allergies etc)?

Do you need to see the Clinical Nurse Specialist before we commence services?

For SIL/Accommodation, Respite, Lifestyles, Packforce only -

When accessing our services, will you require assistance to take any medications?</td><td>☐ Developmentally age appropriate</td><td>☐ Completely independent</td><td>☐ Needs some help</td><td>☐ Needs full assistance</td><td rowspan="2"></td></tr>
<tr><td colspan="4">Does the client have any written health or medical reports or care management plans?
Note for SIL services: current care management plans are required in order to be considered for SIL vacancies at CPA.
☐ Due to complex needs, requires a consultation with the Clinical Nurse Specialist (CNS)
☐ Epilepsy Management Plan
☐ Diabetes Management Plan
☐ Asthma Management Plan
☐ Allergies/ Anaphylaxis Management Plan
☐ Respiratory Management Plan
☐ Medication Assistance Management Plan
☐ Tube Feeding/ Enteral Feeding Management Plan
☐ Bowel Care Management Plan
☐ Medical/ Therapy Reports
☐ Other – please specify (e.g. Dementia Management Plan):</td></tr>
</table>

Skill area	Developmentally age appropriate	Completely independent	Needs some help	Needs full assistance	Current needs/ priorities/ comments
Equipment needs or repairs, or home modifications *Are there any assistive technologies and/or equipment that are required to help you/ your family member to reach goals or support independence?* *(e.g. wheelchair, walker, communication aid, hoist, bed, etc)* *If seeking SIL services: What home modifications are likely to be needed to best support you/ your family member?*	☐ Developmentally age appropriate	☐ Completely independent	☐ Needs some help	☐ Needs full assistance	
	Equipment needs – please tick the ones that apply: ☐ Powered wheelchair ☐ Manual wheelchair ☐ Walking frame ☐ Hoist/ sling ☐ Communication device ☐ AFOs / splints ☐ Home modifications ☐ Other – please specify:				

Client's funding

Funding type:	☐ NDIA Agency Managed ☐ NDIA Self Managed ☐ NDIA Plan Managed ☐ 3rd Party Billing ☐ Self Funded	☐ Medicare ☐ Other Government Funding ☐ CPA Funded ☐ CPA Research	
NDIS Participant Number:		Start date of NDIS Plan:	End date of NDIS Plan:
Plan manager/ financial contact details:	Contact person:		
	Account name:		
	Billing/ invoicing address:		
	Phone:		
	Email address (for electronic billing):		
Medicare card number:		Medicare expiry date:	Medicare line sequence
Funded NDIS categories:	Core Funding ☐ Assistance with Daily Life ☐ Transport ☐ Consumables ☐ Assistance with Social and Community Participation	Capacity Building ☐ Coordination of Support ☐ Improved Living Arrangement ☐ Increased Social and Community Participation ☐ Finding and Keeping a Job ☐ Improved Relationships ☐ Improved Health and Wellbeing ☐ Improved Learning ☐ Improved Life Choices ☐ Improved Daily Living Skills	
	Capital ☐ Assistive Technology ☐ Home Modifications	For SIL services ☐ SIL funding (or eligible for SIL funding) ☐ SDA funding (or eligible for SDA funding) SDA funding level if already assessed: If not assessed, functional assessment will be required before SIL application can progress.	

Client's goals

Client's NDIS goals: (Please provide a copy of NDIS Plan Goals)	Goal 1:
	Goal 2:
	Goal 3:

Client's other services

Do you access any other services? *Day programs/ Employer/ Accommodation provider/ Preschool/ School*	Name:	
	Contact person:	
	Address:	
	Phone:	
	Email address:	
	Attendance:	☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri
Other service provider		
Other service provider		

Client's personal preferences

Appointment preferences	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐

Is there anything you would like our team to know/ be aware of to help prepare for your first appointment/ meeting/ service start? (e.g. sensitivities, likes/dislikes, cultural needs, stress/anxiety triggers)	
All children under 16 are to be accompanied by an adult – unless attending a group program	Please advise who will be attending with the child: ☐ Parent ☐ Carer ☐ Other, please specify:

If you are 16 years or over, and require assistance when you attend CPA services, who would usually accompany you?	☐ Parent ☐ Carer ☐ Other, please specify:
Waiting areas/ reception areas can sometimes be busy or noisy. Do you require any special assistance or supports whilst you wait? (e.g. quiet area, outside area)	

CPA to complete

CSC name:		Date Service Request returned:	