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QF306	INDIVIDUAL SUPPORT PLAN
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Name			
Ambulance Cover			
Entry to home No response process		Key safe number	
Transport			
Allergies/reactions			

COMMUNITY SUPPORT CONTACTS		
Current Community Support Services	Name of Contact	Phone

MEDICAL CONTACTS (GP, SPECIALIST, PSYCHOLOGIST ETC)		
Medical Professional's Name	Address	Phone



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Pharmacy Contact	Address	Phone

A LITTLE BIT ABOUT ME AND MY DISABILITY

MY MEDICAL HISTORY

Eg: Smoker, seizure plan, nursing, nutrition/swallowing, pain relief, treatments, catheter, PEG, use of incontinence aids or any other complex supports

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Is there a medical consent in place? YES / NO
Is there an advanced care directive in place? YES / NO
Copy provided YES / NO

MEDICAL CONSENT			
Name	Start Date	End Date	Contact Details

MY MEDICATIONS				
(i.e. state if you have any PRN medication, as needed medication such as Madazlin, Paracetamol, Nurofin, Diazapan)				
Name of Medication	Dose	Frequency	Route	Purpose

Do I need assistance administering my medication? YES/NO

If yes is there a Medication Authority/Administration log?

YES/NO

If yes has Medical Authority been explained to client and a copy given for GP to complete?

YES/NO

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SUPPORT NEEDS						
Self Care Personal Care		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Communication		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Learning, applying knowledge and general tasks and demands		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					

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Community and economic life		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Working		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Eating and Drinking		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					

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Mobility		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Interpersonal interactions and relationships		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Domestic Life		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					



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Toileting		Not required		Prompting		Standby assistance
		Some support required		Moderate support required		Full support required
	Details					
Dietary requirements	Yes		No			
	Details					
Home alone assessment required	Yes		No			
Home alone assessment completed	Yes		No			

COMMUNITY ACCESS	
Activities attended	



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Likes				
Dislikes				
Animals				
Use of wheelchair				
Does the customer handle their own money?	Yes		No	
Is the customer transported in their own vehicle?	Yes		No	
Is the customer transported in an LA's vehicle?	Yes		No	

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INDIVIDUAL SUPPORT PLAN

MANUAL HANDLING

Eg: Lifter, one person or 2 person assist, shower chair/commode, bed pan, slide board and slide sheet

ALERTS FOR SUPPORT NOTES

ANY SPECIAL REQUIREMENTS FOR LA'S

i.e special training, qualifications



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Are there any care plans or behaviour plans?	Yes		No	
Has a copy been provided to the office?	Yes		No	
Can you provide us with a copy of your NDIS plan if you have received it (goals etc)	Yes		No	

COMMUNICATION BOOK
What information would you like included?