Preparation and Support Summary for Your NDIS Planning Meeting

Name: ____________________________
Date of meeting: ___________________
Present at meeting:

This document is for personal use only and may not be reproduced in any format without written consent from Cerebral Palsy Alliance

T 1300 888 378 | W cerebralpalsy.org.au
My Life Needs
What are your current goals & hopes?

Physical health
- What activities/tasks do you/your child have difficulties doing?
- Do you/your child need support with personal care?
- Do you/your child experience any pain or discomfort?
- How do you look after your/your child’s health?

Recreation, leisure & holidays
- What are your/your child’s hobbies and interests?
- What do you & your family enjoy doing?
- Do you and your family take trips/holidays?

Work or Community participation
- How do you/your child spend time day to day?
- What activities do you/your child hope to do in the future?

Relationships & Informal supports
- Who supports you/your child?
- Who are the most important people in your/your child’s life?

Home & home help
- How do you manage your home and household tasks?
- Do you/your family need a break?
- Do you/your child need any assistance in the home?
What is important to you about money?

Do you need any assistance with managing money, funding or finances?

What is important to you and your family?

How do you make sense of what you are going through?

What has been the impact on you/your family of receiving the diagnosis of disability?

How are you feeling about what’s happening with you or your child at the moment?

What do you/your child dream of achieving in life?

Do you/your child need assistance with learning or life skills?

How do you/your child get around?

Do you/your child need any assistance with travel?
My Check-Up

What are your current needs or concerns with managing your disability?

**My Disability**
Do you/your child have a disability? Y / N
If known, what type of disability do you/your child have?

What part(s) of the body are involved, please indicate on stick figure.

Do you/your child have an intellectual disability? Y / N / Unknown
If yes, what level of intellectual disability do you/your child have:
- Borderline
- Mild
- Moderate
- Severe
- Profound

Do you/your child demonstrate any behaviours that impact on everyday life? Y / N
If yes, would you describe the behaviour as:
- Mild
- Moderate
- Severe

**My general health & wellbeing**
Do you have any worries or concerns about your/your child’s general health? Y / N
Do you/your child experience pain? Y / N
Do you/your child have difficulties with sleep? Y / N
Do you/your child take any medications? Y / N
Do you have concerns about your/your child’s vision? Y / N
Do you have concerns about your/your child’s hearing? Y / N
Do you/your child have difficulties with continence/constipation? Y / N
Do you/your child have any difficulties with epilepsy? Y / N

Do you have any worries or concerns about how you/your child is coping at the moment? Y / N
Do you have any worries or concerns about how other family members are coping at the moment? Y / N
Do you have concerns about how you and your partner are going as a couple at the moment? Y / N

**Child specific:**
Do you have any worries or concerns in relation to parenting or taking care of your child with a disability or their siblings? Y / N

**My mobility & independence**
Do you have any worries or concerns about your/your child’s gross motor skills, walking or coordination? Y / N

How do you/your child move around?
- Walk without limitation
- Walk with some limitation in some circumstances
- Walk with mobility aid (including wheelchair for longer distances)
- Rely on wheeled mobility for movement (uses wheelchair or powered mobility)
- No means of independent mobility - relies on assistance

Have you/your child experienced any changes in mobility/function? Y / N (question to identify any possible degeneration)

Do you/your child use any splints or orthotics for legs and feet? Y / N
If yes, do you have any concerns with how these are fitting/being used? Y / N

Have you/your child had or are due to have botulinum toxin injections in the legs? Y / N
If yes, when? ___ / ___ / ___

When was your/your child’s last hip x-ray done ___ / ___ / ___

Have you/your child had any surgery for the legs and feet or is any surgery planned? Y / N

Are you aware of any changes in the alignment of your/your child’s spine? Y / N

**My/Family concerns in this area:**

My/Family concerns in this area:

My/Family concerns in this area:

My/Family concerns in this area:

☐ Assessment
☐ Intervention
☐ Referral to: _____________
**My technology, equipment & independence**

Do you have any worries or concerns about your/your child’s hand (fine motor) skills? Y / N

Do you have any worries or concerns about you/your child’s self-care skills? Y / N

How do you/ your child use your hands?
- [ ] Handles objects easily & successfully
- [ ] Handles most objects but with somewhat reduced quality and/or speed of achievement
- [ ] Handles objects with difficulty; needs help to prepare and/or modify activities
- [ ] Handles a limited selection of easily managed objects in adapted situations
- [ ] Does not handle objects and has severely limited ability to perform simple actions.

Do you/your child use any splints or orthotics for arms and hands? Y / N

Have you/your child had or are due to have botulinum toxin injections in the arms? Y / N

If yes, when? ___ / ___ / ___

Do you/your child use any aids or equipment? Y / N

Do you currently have any questions about the use and access to assistive technology e.g. equipment provision, seating, powered mobility, computer access, and communication? Y / N

Do you currently have any questions about transport e.g. car seat, vehicles, getting around? Y / N

Do you currently have any questions about environmental modifications e.g. home setup & access? Y / N

**My swallowing & communication**

Do you or your child have any concerns with communication? Y / N

How do you/your child communicate?
- [ ] Verbally
- [ ] Non-verbally
- [ ] Combination of verbal & augmented communication

Do you/your child find it difficult to get a message across with familiar people? Y / N

Do you/your child find it difficult to get the message across with unfamiliar people? Y / N

Do you/your child have concerns with understanding others/instructions? Y / N

Do you/your child have concerns with social communication skills? Y / N

Do you/your child seem to get frustrated if can’t get a message across? Y / N

Do you have any worries or concerns about your/your child’s mealtimes/swallowing? Y / N

Do you/your child have difficulties swallowing food? Y / N

Do you/your child have difficulties drinking? Y / N

Does it take more than 25 minutes for you/your child to have a meal? Y / N

Are you concerned about your/your child’s weight? Y / N

Are you concerned about your/your child’s nutrition? Y / N

Do you/your child have difficulty in managing saliva? Y / N

**My learning & participation**

Do you currently have any questions about your/your child’s progress or general development? Y / N

Do you have any worries or concerns about your/your child’s ability to participate in daily life? Y / N

Do you have any concerns about your/your child’s self-esteem, feelings or emotions? Y / N

Do you have any concerns about how you/your child get along with others? Y / N

Would you like the opportunity to connect with others e.g. parents, families and/ or people with disability? Y / N

Do you need any information about funding, resources and other supports available for you/your child or family? Y / N

Would you like support with your/your child’s participation in community activities e.g. sport, leisure, play? Y / N

---

**My/Family concerns in this area:**

- [ ] My/Family concerns in this area:
- [ ] My/Family concerns in this area:
- [ ] My/Family concerns in this area:

- [ ] Assessment
- [ ] Intervention
- [ ] Referral to: ____________________

- [ ] Assessment
- [ ] Intervention
- [ ] Referral to: ____________________

- [ ] Assessment
- [ ] Intervention
- [ ] Referral to: ____________________

---

T 1300 888 378 | W cerebralpalsy.org.au
# My formal & informal supports & services

(Include detail of type of service/support & number of hours this service/support is provided/needed)

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MORNING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future needs for services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAYTIME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future needs for services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AFTERNOON</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future needs for services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EVENING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future needs for services &amp; supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day</td>
<td>Morning</td>
<td>Daytime</td>
<td>Afternoon</td>
<td>Evening</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>---------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contact: T 1300 888 378 | W cerebralpalsy.org.au
## Current Aids & Equipment

<table>
<thead>
<tr>
<th>Type of aid/equipment</th>
<th>How often is the aid/equipment used?</th>
<th>How well is it working?</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Current Aids & Equipment

<table>
<thead>
<tr>
<th>Type of aid/equipment</th>
<th>What is the purpose of the aid/equipment/where will it be used?</th>
<th>How often is the aid/equipment to be used?</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Do you feel you will need support/assistance to coordinate your plan and/or your personal budget?  
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Any reports or materials to take with you to your appointment?
Some suggestions:
☐ Medical Reports
☐ Therapy Reports
☐ Existing Individual/Family Service Plans
☐ Other: _________________________________

What are you hoping for or expecting from the National Disability Insurance Agency (NDIA) as your funding support provider?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What are you hoping for or expecting from Cerebral Palsy Alliance as your service provider?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Questions (that you raised with Cerebral Palsy Alliance) to remember for your appointment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
We have centres throughout NSW and ACT - visit cerebralpalsy.org.au to find your nearest service.