CDNI Care

Exit and Transition Form

Your Details	
Client First Name:	
Client Last Name:	
Client Date of Birth:	

Representative or Emergency Contact Details	
First Name	
Last Name	
Relationship to Client	

About you	
Living Situation	☐ Own home (alone) ☐ Own Home (with family) ☐ Supported Accommodation ☐ Temporary ☐ Other: ______________________________
Aboriginal or Torres Strait Islander descent?	☐ Yes ☐ No
Does the Client have a current Behavioural Support Plan	☐ Yes ☐ No
Primary Formal Diagnosis	
Secondary Formal Diagnosis	
Any allergies? If yes please provide below	

Medical diagnosis and medicine that may affect the support provided	
Name and contact number for Client's Doctor	
Any legal issues that may affect service eg. Apprehended Violence Order	

Communication	
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other: ______________________
Is the Client of a culturally or linguistically diverse background?	☐ Yes ☐ No
Languages Spoken	☐ English ☐ Other: ______________________
Is an Interpreter required?	☐ No ☐ Hearing Impaired ☐ Language

CDNI Care
Exit and Transition Form

Mental Health			
I have/experience...			
☐	Depression	☐	Anxiety
☐	Psychosis	☐	Schizophrenia
☐	Bipolar	☐	Other
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			
☐	CDNI Care may provide a copy of any relevant management plans to any new provider.		

Physical Health			
I have...			
☐	Diabetes	☐	Sleep Apnoea
☐	Epilepsy	☐	Dietary Needs
☐	Asthma	☐	Blood Disorders
☐	Visual Impairment	☐	Hearing Impairment
☐	Cognitive Impairment	☐	Heart Conditions
☐	Allergies to:		
☐	Other:		
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			
☐	CDNI Care may provide a copy of any relevant management plans to any new provider.		

CDNI Care
Exit and Transition Form

Transition Risks	Comments	Strategies	Who is responsible?	Monitor and Review

Consent
The Client consents to CDNI Care: (a) providing and discussing your Plan with any new providers of your supports and services identified by you to us to enable a planned and documented transition of supports (b) discussing you (including any risks associated with transitioning your care) with any new providers of your supports and services identified by you to us to enable a planned and documented transition of supports (c) releasing copies of your all existing records relating to such supports and services (except for those records which CDNI Care is not required to release under applicable law) **Signed** by the Client: ……………..…………………………….. Signature ……………..…………………………….. Name (please print) **Signed** by the Representative: ……………..…………………………….. Signature ……………..…………………………….. Name (please print)