

NDIS Functional Capacity Assessment Report Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An NDIS functional capacity assessment report documents how a person's disability affects everyday functioning across six domains, communication, social interaction, learning, mobility, self-care and self-management, and recommends supports as evidence for NDIS access and planning decisions. No law mandates it; the quality of the evidence is what decides.

Identifying details & referral context which decision is this report for

Do: record participant, DOB, NDIS number, dates, assessor registration, who asked, and the purpose in one sentence.

Pitfall: no stated purpose; the recommendations float free of the decision they are meant to inform.

Background: diagnoses & current supports cite the diagnostic reports, do not re-argue them

Do: list diagnoses with source and date, medications' functional effects, living and work arrangements, informal care.

Pitfall: restating the diagnosis as if it were function; a diagnosis says nothing yet about most days.

Assessment methods & presentation list everything the findings rest on

Do: name interviews, observation including any home visit, informants, tools with versions, records, and modality.

Pitfall: one office visit and no second source reads as a snapshot, not an assessment.

Standardized measures & scores Vineland-3, ABAS-3, WHODAS 2.0; none is mandated

Do: report scores, then translate each into daily life; say why the tool fits the question.

Pitfall: a low composite means nothing to a planner until it becomes the kitchen bench or the bus stop.

Functional capacity by domain the core: all six, on most days

Do: cover all six domains across settings, with and without support, and say which one you observed.

Pitfall: best-day reporting; one observed success generalised into independent collapses at review.

Informant reports & observation triangulate, then reconcile

Do: tie every account to its source; address disagreements and state what you weighted and why.

Pitfall: self-care intact on one page, daily bathing prompts two pages later, and no comment on either.

Strengths, informal supports & risk planner-credible, participant-respectful

Do: document what the person does well, what informal care carries and its sustainability, risks and management.

Pitfall: a deficits-only report reads as advocacy and fails the person who will read their own record.

Functional impact summary plain language a non-clinician can quote

Do: name the domains substantially reduced, the evidence behind each, and the effect on work, study and social life.

Pitfall: statutory phrases with no evidence chain persuade no one who is paid to test them.

Recommendations & support needs supports, not therapy goals

Do: dose every support, type, frequency, duration, rationale, tracing the impairment to the need.

Pitfall: ongoing support with daily living gives the planner nothing to fund.

Before you sign

- ☐ Purpose and decision stated up front
- ☐ Every domain finding has a named source
- ☐ With-support and alone kept distinct
- ☐ Home or community evidence included
- ☐ Discrepancies between sources addressed
- ☐ Impact summary backed by domain evidence
- ☐ Each support dosed: type, frequency, duration

Drafting with AI

Capture 30 seconds of bullets after the last session: methods, domain findings by source, strengths, impact, dosed supports.

"Draft an NDIS functional capacity assessment report from these notes, 21-year-old participant, plan reassessment, home observation plus mother interview, Vineland-3 composite 68, substantially reduced self-care and self-management, recommending 6 hours per week of daily-living support: ..."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

15 to 30 pages
typical length

1 to 10 hrs assessing
NDIA published range

6 domains
communication to self-care

Planner · participant
who reads it

NDIS Functional Capacity Assessment Report Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Participant (initials): _____ DOB / age: _____ NDIS no.: _____ Assessment date(s): _____

Assessor / registration: _____ Requested by + purpose: _____ Report date: _____

Referral context

The decision this report informs: access, plan reassessment, change of circumstances, or a specific support question

Background: diagnoses, history & current supports

Diagnoses with source and date; medications and functional effects; living, work and study; informal supports in place

Assessment methods & presentation

Interviews and settings; observation incl. home or community; informants; tools with versions; records reviewed; modality; presentation

Standardized measures & scores

Tool, version, respondent; scores with their daily-life translation; why each tool fits the question

Functional capacity by domain

Communication; social interaction; learning; mobility; self-care; self-management. On most days, with and without support

Informant reports & observation

Each account tied to its source; discrepancies addressed and weighted

Strengths, informal supports & risk

Strengths and goals; what informal care carries and whether it is sustainable; risks and current management

Functional impact summary

Plain language; domains substantially reduced and the evidence; effect on work, study and social participation

Recommendations & support needs

Each support: type / frequency / duration / rationale tracing impairment to need; fit with informal supports; reassessment trigger

Assessment hours: _____ Signature / registration: _____ Date signed: _____