HALE COMMUNITY SUPPORT

APPLICATION TO BECOME A PARTICIPANT MEMBER

ALL INFORMATION STRICTLY CONFIDENTIAL

LAST NAME:_____

GIVEN NAME _____

D.O.B _____

ADDRESS: _____

_____

PHONE: _____ **MOBILE:** _____

EMAIL : _____

DOES THE APPLICANT IDENTIFY THEMSELVES AS AN ABORIGINAL OR TORRES STRAIT ISLANDER PERSON?

DOES THE APPLICANT / FAMILY IDENTIFY THEMSELVES FROM A CULTURAL BACKGROUND?

CARER'S NAME: _____

EMERGENCY PHONE: _____

WILL CARER PROVIDE TRANSPORT? YES/NO

MEDICAL:

PRIMARY DIAGNOSIS:

<u>OTHER DIAGNOSIS</u>:

CONSENT TO CALL AMBULANCE OR MEDICAL ASSSTANCE IF REQUIRED?

YES / NO

CAN THE PARTICIPANT ADMINISTER MEDICATION? YES/NO

IF NO, PLEASE PROVIDE MEDICATION IN WEBSTER'S PACK AND LET STAFF KNOW.

LIST ALL MEDICATIONS:

SPECIAL NEEDS OF PARTICIPANT. (Please include mobility, personal care, dietary, medical, allergies, epilepsy or diabetes management plan (where applicable), emotional.

DOES THE PARTICIPANT DISPLAY ANY CHALLENGING BEHAVIOURS THAT POSE A SIGNIFICANT RISK TO THEMSELVES AND OR OTHERS? IF YES, PLEASE LIST AND PROVIDE BEHAVIOURAL SUPPORT PLAN.

LIKES /DISLIKES

PRIVACY

The Privacy act requires the applicant to sign this form giving their consent for the release of their information and details.

The referrer and the applicant agree that no information has been withheld; all information is accurate, correct and necessary for the Pacific Islands Support Association to provide a Duty of Care to the service recipient and to meet its obligations to staff.

APPLICANTS SIGNATURE: …….. DATE:

REFERERS SIGNATURE: …….. DATE:.

PLEASE FORWARD THIS COMPLETED FORM AND ATTACHMENTS TO:

Intake & Assessment Team
Hale Support Respite – Community Support

hcsintake@halesupport.org.au – 02 9625 5076