ALORA RETREAT

[Form-2001]

Client Information and Authority

Personal Information

Last Name

First Name

Preferred Name

Date of Birth

Phone

Address

Primary Disability

Secondary Disability

Medicare No.

Private Health Fund

Membership No.

Arrival Date

Departure Date

Length of Stay

Likes/Dislikes

Hobbies

Next of Kin / Emergency Contact

Name

Contact Phone

Relationship

Other Contacts Name

Phone No.

Referring Agency

Referring Agency and Name

Email

Phone

Current Situation

What is the need for Short Term Accommodation?

NDIS

Do you have an NDIS Plan? ☐ Yes ☐ No

Plan start date: **Plan end date:** **NDIS No.**

☐ **Agency Managed** ☐ **Self-Managed** ☐ **Plan Managed** (if yes, please provide Plan Manager's details)

Plan Manager's Name **Email** **Phone**

Do you have an NDIS Coordinator? ☐ Yes ☐ No

Has your Support Coordinator been informed of your stay with us? ☐ Yes ☐ No

Support Coordinator Name **Company** **Phone**

Transportation

Do you have transportation included in your NDIS plan? ☐ Yes ☐ No

☐ **Agency Managed** ☐ **Self-Managed** ☐ **Plan Managed**

Do you have a companion card? ☐ Yes ☐ No

Do you have a taxi subsidy card? ☐ Yes ☐ No

Do you have a Translink Access card? ☐ Yes ☐ No

Medical Contacts

General Practitioner

Address **Phone No.**

Treating Hospital **Phone No.**

Medical Information

General Medical Information

Condition	Yes	No	Comments
Diabetic			
Asthma			
Anaphylaxis			
Epilepsy			
Heart condition			
Any other concerns not listed?			

Behaviours, Concerns and Triggers

Are there any behaviours of concern, triggers or thing to be mindful of?

Do you have a Positive Behaviour Support Plan? ___ Yes, attached ___ No

*Ratios are determined on the level of care assessed at intake and are subject to change.

Do you have any other supporting evidence? E.g. Functional Capacity Assessment, psychological assessment, hospital discharge summaries or any other type of allied health assessment.

___ Yes, listed below and attached ___ No

Medication

Do you currently take any prescribed medication? ___ Yes, medication chart attached ___ No

Allergies

Please list any allergies you have including material/drug and how the adverse reaction presents. Please also list the response and management strategies.

Request for Medical Assistance

☐ I hereby request management/staff of Alora Retreat to assist me with my medication as prescribed by my medical practitioner. I also understand that:

- this means assisting me at the correct times to access my prescribed medication from its container which has been dispensed by a registered pharmacist.
- this means assisting me to access appropriate non-prescription medication in accordance with the directions provided by the manufacturer.
- this means assisting me with alternate medications recommended by my medical practitioner and/or pharmacist.
- Alora Retreat will safely store such medication in a locked area within the facility.
- my prescriptions will be given to the pharmacist as required.
- if I am not present at the agreed time and location to receive assistance with medication, management/staff will make all reasonable efforts to locate me. Third parties Alora Retreat may contact include family, friends, government agencies and emergency services. If unfound, Alora Retreat will report to the appropriate people, clinics and/or medical practitioners immediately.
- should I miss a dose for any unplanned reason, or if I refuse to take the prescribed medication, I do so at my own risk, and that staff will notify my medical practitioner.

Name

Signed	**Date**

Signature of Authorised person (substitute decision maker)	**Date**

Relationship / status

Consent to be Photographed

During your stay with us, Alora Retreat may be taking photographs or video footage to use in promotions that may include but not limited to materials such as brochures, newsletters, websites and social media. Do you give us permission to use photographs, images, and/or video taken of you in such promotions?

Please tick: ☐ Yes ☐ No

I acknowledge that copies of photographs and video footage involving me can be obtained from Alora Retreat by making a written request.

Authority to Share Information

I, the undersigned, do hereby grant permission to Alora Retreat to collect and disclose information which is relevant to the support services provided. I understand throughout the provision of my regular and ongoing support, Alora Retreat will use this consent as authority to collect and disclose my information to/from relevant third parties and agencies required to provide these support services.

Alora Retreat may disclose my personal information to:

- Alora Retreat related entities to facilitate internal business processes
- Commonwealth and State departments and agencies which provide funding for services (i.e. NDIS Auditing purposes, Office of Public Guardian, Public Trust, NDIA)
- Contractors and/or agencies who provide on behalf of Alora Retreat
- Your NDIS registered Support Coordinator and/or your Plan Manager
- Other NDIS service providers who offer supports (i.e. Centacare, Endeavour)
- Health and allied health professionals who provide specialist support to facilitate the delivery or support services (i.e. GP, physiotherapist, hospitals)
- Third parties including Queensland Police Service, to help with identification in the case of missing persons, and
- Emergency medical and ancillary staff in an emergency.

I understand that it is my right to choose if specific organisations are excluded from accessing or receiving information Alora Retreat holds about me. Therefore, by indicating in writing below, I **DO NOT** give authority to Alora Retreat to contact or disclose my information to the following:

Name

Signed	**Date**

Witnessed by	**Date**

Criminal History Declaration

Criminal History:

☐ Yes ☐ No

If YES, please provide info:

Risk Assessment

Do you have a risk assessment from another service provider/health facility? Please attach.

☐ Yes ☐ No

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Assessor's Name	Date of Arrival	Date of Departure