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| INFORMATION |

**Date completed:** Click here to enter a date.

**Scheduled review date:** Click here to enter a date.

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| **Name** |  | | | | | | | | | **Person’s photo** | | | | |
| Date of birth |  | | | Gender | |  | | | |  | | | | |
| Phone |  | | | | | | | | |
| Email |  | | | | | | | | |
| Address |  | | | | | | | | |
| Parent/  Guardian |  | | | | | | | | |
| Height (cm) |  | | | Weight (kg) | |  | | | |
| Hair colour |  | | | Eye colour | |  | | | |
| Complexion |  | | | | | | | | |
| Religion |  | | | Language | |  | | | |
| Cultural background | |  | | | | | | | |
| Distinguishing features | |  | | | | | | | | Electoral enrolment | | | | Yes  No |
| Disability | |  | | | | | | | | | | | | |
| Medical conditions | |  | | | | | | | | | | | | |
| Medication | | Refer to current medication chart | | | | | | | | | | | | |
| Behaviours | |  | | | | | | | | | | | | |
| Vision impairment | | Yes  No | | | Hearing impairment | | | | Yes  No | | Dentures | | Yes  No | |
| Communication needs | | Verbal  Written  Makaton  Compic  Auslan  Other: | | | | | | | | | | | | |
| Mobility | | Independent  Semi-independent  Requires full support | | | | | | | | | | | | |
| Mobility aid | | Does not require aid  Walking stick  Wheelchair  Other: | | | | | | | | | | | | |
| Allergies | |  | | | | | | | | | | | | |
| Pension number | |  | | | | | Medicare number | | | |  | | | |
| Health care fund | |  | | | | | Health fund number | | | |  | | | |
| Centrelink ref number | |  | | | | | Expiry date | | | |  | | | |
| Medical practitioner name and address | |  | | | | | Dentist name and address | | | |  | | | |
| Other important people | |  | | | | | | | | | | | | |
| Other details | |  | | | | | | | | | | | | |
| **Emergency contact details – primary contact** | | | | | | | | | | | | | | |
| **Name** | | |  | | | | | | | | | | | |
| **Address** | | |  | | | | | | | | | | | |
| **Phone** | | |  | | | | | **Mobile** | | | |  | | |
| **Email** | | |  | | | | | | | | | | | |
| **Relationship** | | |  | | | | | | | | | | | |

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| **Emergency contact details – secondary contact** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Relationship** |  | | |

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| **Other important contact details** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Relationship** |  | | |

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| **Does the person have a legally appointed guardian? Yes  No** | | | | |
| **Name** |  | | | |
| **Address** |  | | | |
| **Phone** |  | **Mobile** |  | |
| **Email** |  | | | |
| **Guardianship function** | Accommodation  Services  Medical and dental  Restricted practices  Financial  Other (provide details below) | | | |
| **Does the person have a substitute decision maker/designated person responsible?**  **Yes  No** | | | | |
| **Name** |  | | | |
| **Address** |  | | | |
| **Phone** |  | **Mobile** | |  |
| **Email** |  | | | |

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| **Does the person have an advocate? Yes  No** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| **Does the person have a financial manager? Yes  No** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| **Does the person have a power of attorney? YES  NO** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| **Banking details** | |
| **Name of bank** |  |
| **Address of bank** |  |
| **Do they use** | **ATM  Bank book** |
| **Days they do banking** |  |
| **What was the outcome of the tool?** |  |
| **Have they chosen to have support by staff with managing their budget?** | **Yes  No  N/A**  **If Yes, how** |

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| **Medical professional details** | |
| **General practitioner** |  |
| **Phone** |  |
| **Address** |  |
| **Psychiatrist** |  |
| **Phone** |  |
| **Address** |  |

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| **Other important medical professional details** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| **Other important medical professional details** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| --- | --- | --- | --- |
| **Other important medical professional details** | | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |

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| **Medical conditions**  (Please list all diagnosed conditions below. For suspected conditions specify e.g. ‘query – dementia’) |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| **Allergies or medical allerts**  (Please list all known allergies or medical alerts and reference to the appropriate course of action) |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

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| **Employment details** | | | |
| **Business name** |  | | |
| **Business address** |  | | |
| **Business phone** |  | **Mobile** |  |
| **Business email** |  | | |
| **Contact person** |  | | |

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| **Community support** | | | |
| **Support received** | **Self managed:  Centre based:  Other:  If other, please explain below.** | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Contact person** |  | | |
| **Days attending or receiving support** |  | | |

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| **Community support** | | | |
| **Support received** | **Self managed:  Centre based:  Other:  If other, please explain below.** | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Contact person** |  | | |
| **Days attending or receiving support** |  | | |

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| **Community support** | | | |
| **Support received** | **Self managed:  Centre based:  Other:  If other, please explain below.** | | |
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| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Contact person** |  | | |
| **Days attending or receiving support** |  | | |

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| --- | --- | --- | --- |
| **Community support** | | | |
| **Support received** | **Self managed:  Centre based:  Other:  If other, please explain below.** | | |
| **Name** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Contact person** |  | | |
| **Days attending or receiving support** |  | | |

This section is optional for additional notes

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| **Document Title: Operations – Disability – Accommodation – Information Pack - Form** | **Document Custodian – Chief Operating Officer** |
| **Last Review Date: 28 May 2020** | **Next Review Date: 28 May 2022** |