*The Exit & Transition Plan Form is to be utilised for participants who are seeking to exit Nurturing Hands Allied Health P/L’s services indefinitely or temporarily. To ensure the approval of this form, it must be completed by both the participant and all relevant parties.*

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| **Participant Details** |

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Given Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Birth:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Advocate/Guardian Details (If Applicable)** |

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Nurturing Hands Allied Health P/L’s Details** |

Business Name: Nurturing Hands Allied Health P/L

Registered Business Address: 1/9 Berkley Street

Suburb: Wantirna South State: Vic Postcode: 3152

Mobile Number: 0419 54 59 51

ABN / ACN: 70 682 252 598

Nurturing Hands Allied Health P/L will work closely with external agencies to coordinate the best support and care for you.

All confidential information that you have provided will remain disclosed and respected, unless Nurturing Hands Allied Health P/L is subjected to do so in the following situations:

* *We are obliged by law to disclose your private and confidential information, regardless of authorisation provided;*
* *It is unreasonable or impracticable to gain consent or consent has been refused;*
* *The disclosure of information is necessary based upon reasonable grounds, to assist in preventing or lessening a serious threat to the life, health, wellbeing, or safety of an individual, or group of people.*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby acknowledge that Nurturing Hands Allied Health P/L has advised me of the following:

* *Nurturing Hands Allied Health P/L’s Privacy and Confidentiality Policy and Procedure;*
* *My right to access my personal information; and*
* *My right to withdraw my consent at any time.*
* I understand that the following service(s) are recommended and relevant information about me may be forwarded to the agency(s) that provide these services, in order that I receive the best possible service:

(Insert names of third parties as agreed with the participant, e.g. Home and Community Care (HACC), Aboriginal Health Worker, Youth Worker.)

* *I understand that Nurturing Hands Allied Health P/L must comply with relevant privacy laws and I will contact the organisation immediately if I feel that these laws have been breached.*
* *My worker has discussed with me how and why certain information about me may need to be provided to other service providers.*
* *I understand the recommendations and I give my permission for the information to be shared with the people or agencies as detailed above.*

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of Participant or Authorised Representative | Signature | Date |
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| Name of Nurturing Hands Allied Health P/L Staff Member | Signature | Date |

**External Services**

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| **New Service Information** |

Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Registered Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_

Office Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABN / ACN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temporary Transition: Yes / No

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| **Transition Information** |

Reasoning for Transition / Exit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Risks associated with transitioning/ Exit of the participant**  |

*Outline any risks that apply to the transition/exit of the participant:*

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| **Risks/Opportunities Identified:** |
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*If any risks were identified what steps will be taken to minimize them:*

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| **Risks/Opportunities Identified:** | **Contingency plan:** |
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| **Participant Documents** |

*The following outlines examples of documents in which Nurturing Hands Allied Health P/L will pass on to the service provider of the participant. (Please complete the following checklist to reflect the exact documentation that will be provided to the participant’s future service provider).*

* Care Plans
* Referral Forms
* Medication Plans
* Medication Consent Forms
* Support Plans
* Consent Forms
* Progress Notes

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| **Authorisation of Transition to a New Service Provider** |

* I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to the transition/temporary transition/exit from Nurturing Hands Allied Health P/L to *[insert new service provider business name].*
* I agree to my personal files, documentation and information being transferred and disclosed to my new service provider.

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| Name of Participant or Authorised Representative | Signature | Date |
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| Authorisation by Nurturing Hands Allied Health P/L  | Signature | Date |

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| Authorisation of new Service Provider | Signature | Date |