



Inc. No. A0033301C ABN 76 139 165 672

WRESACARE is a Not-For-Profit Community Managed Organisation providing services to People with Special Needs and their Carers.  
Donations of \$2 or greater to WRESACARE are Tax Deductable.

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## CONFIDENTIAL CLIENT INFORMATION Part A

### SERVICE REQUIRED (Please tick where appropriate)

- In-home support/Community access    Social Groups    School Holiday Program
- Children's Respite House    Other: Please specify \_\_\_\_\_

If you have a staff preference please indicate:    Female    Male

### CLIENT DETAILS

Person requiring service: \_\_\_\_\_

(First name)

(Surname)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male  Female

Address \_\_\_\_\_

Postcode: \_\_\_\_ Telephone Number: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Language(s) spoken at home: \_\_\_\_\_ Is an interpreter required?: \_\_\_\_\_

Are there any cultural/religious issues that we need to be aware of?: \_\_\_\_\_

Koori or Torres Straight Islander?:    Yes    No

Name of school or work/day placement (if applicable): \_\_\_\_\_

What is the service user's main source of income?: \_\_\_\_\_

Is the client registered with the Department of Human Services? (This applies to people with an

intellectual disability only over the age of 6yrs).    Yes    No

Please document all family member's living at home/residence:

Name	Date of Birth	Relationship to client

Is there more than one person with a disability in the carer household?  Yes  No

If yes, how many \_\_\_\_\_

Do you have a case manager?  Yes  No

If yes, please provide name and contact number: \_\_\_\_\_  
\_\_\_\_\_

**PRIMARY CARER DETAILS** (Parent, Guardian or usual carer)

Contact Person: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Business: \_\_\_\_\_

How would you describe the health of the primary carer?

Good  Average  Poor  Very poor

Does the carer of the household rely on the pension as its sole income?  Yes  No

**ALTERNATE EMERGENCY CONTACT**

Contact Person: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Business \_\_\_\_\_

**MEDICAL DETAILS**

Medical Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Paediatrician/Specialist: \_\_\_\_\_ Speciality: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Health Care Card Details: \_\_\_\_\_

Private Health Insurance Details: \_\_\_\_\_

Ambulance Membership Number): \_\_\_\_\_

Companion Card Number: \_\_\_\_\_

**DESCRIPTION OF CLIENT'S PRIMARY DISABILITY**

Intellectual       Physical       Dementia       Acquired Brain Injury (ABI)

Sensory: (Visual  Hearing  )       Psychiatric       Epilepsy       Frail Aged

Other (please specify ( e.g. Autism etc)

Diagnosed by: \_\_\_\_\_

When: \_\_\_\_\_

Is there any specific medical condition? :       Yes       No

If yes, please provide information: \_\_\_\_\_

**METHOD OF COMMUNICATION (tick all relevant boxes)**

Verbal       Communication aids       Gesture

Compic       Makaton/sign       Other (please specify)

Further Details: \_\_\_\_\_

**MOBILITY**

Is assistance required when walking?  Yes  No

(if no, please proceed to next section)

Is an aid used to assist mobility? (If yes, please describe.)  Yes  No

Additional comments (i.e. Require assistance transferring from wheelchair),

Can the applicant weight bear?  Yes  No

If no, do the staff have access to:

Hoist,  Yes  No Shower chair  Yes  No

Ramps  Yes  No Other aids  Yes  No

Is support required while traveling in car/bus:  Yes  No

Is extra support required when crossing roads :  Yes  No

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**PERSONAL CARE REQUIREMENTS**

Are continents aids/nappies required?  Yes  No

Is personal care assistance required?  Yes  No

Assistance with Menstrual management:  yes  No

(if applicable)

Does the Client have any medical requirements that would require specific training?  Yes  No

PEG Feeding  Catheter  Suction  Other

If yes to any of the above describe the usual procedure followed: \_\_\_\_\_

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**EATING/ DRINKING ASSISTANCE**

Independent (If no, please fill in below.)  Yes  No

Please provide any relevant instructions: \_\_\_\_\_

\_\_\_\_\_

Is there any special diet?  Yes  No

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GENERAL HEALTH OF CLIENT**

Are there any allergies? :  Yes  No

This may include, food, medications, band-aids, or sunscreen.

If yes, please describe how this may present:

\_\_\_\_\_

\_\_\_\_\_

What action should be taken? :

\_\_\_\_\_

\_\_\_\_\_

Are there any other health or medical issues? (e.g. Diabetes)  Yes  No

If yes, please describe: \_\_\_\_\_

Outline any implications this may have: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EPILEPSY:**

Does the individual have epilepsy or other fits or seizures?  Yes  No

Type: \_\_\_\_\_ How often? (weekly, monthly or other) : \_\_\_\_\_

Warnings: \_\_\_\_\_

Triggers: \_\_\_\_\_

Please describe any distinguishing features: \_\_\_\_\_

How long do they last: \_\_\_\_\_

Management and recovery : \_\_\_\_\_

Other advice: \_\_\_\_\_

**Under WRESACARE Policy staff are NOT able to administer rectal Valium or any invasive procedure. An Ambulance will be called if a seizure lasts more than 3 minutes**

**MEDICATION :**

Is there any regular medication taken?  Yes  No

Is medication taken **without** staff assistance?  Yes  No

If yes, please describe (list medications on table supplied):

**(Please Note: WRESACARE does not take responsibility for individuals who self medicate. This applies to individuals over the age of 18 years only. In such cases, staff will ensure that all participants/clients in their care will be reminded to take any medications, and take all necessary precautions).**

Please provide full details of all medications (e.g. Name of drug, dosage, etc.):

Name of Medication	Reason for Medication	Time (i.e. 7am)	Dosage (mg)	Special Instructions	Name of Prescribing Dr.	Speciality

## BEHAVIOUR MODIFYING MEDICATION

Name of Medication	Reason for medication	Time (i.e. 7am)	Dosage	Special Instructions	Name of Prescribing Dr.	Speciality

**N.B ALL tablet medication must be in a dosette box and clearly identified on a WRESACARE medication form before being administered by WRESACARE staff.**

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### OTHER INFORMATION

Please provide any other useful information that may assist staff: e.g. daily patterns) \_\_\_\_\_

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Likes:	Dislikes:

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I give permission to **release** or **obtain** information **to** or **from** other Agencies or Medical Practitioners where necessary? Yes  No

I give permission to publish photos for inclusion of WRESACARE documentation ? Yes  No

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## **BEHAVIOURAL PLAN**

As part of our funding requirement it is essential that the following be completed accurately and any future changes be notified.

Has a Behavior Support Plan and/or Person Centred Plan (P.C.P.) been completed by your Case Manager, school, day placement or work setting?                      Yes                       No

(If yes, please attach a copy of the latest document to assist WRESACARE to provide appropriate services to each individual).

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### **BEHAVIOURS OF CONCERN :**

<b>Behaviours of concern</b>	<b>Triggers/warnings signs</b>	<b>Strategies</b>

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## Part B

### Information supplied to WRESACARE by Applicants Case Manager

**Client Name** .....

**To be completed by your Case Manager**

What other services are currently used (including council, other respite services, Making a Difference etc.)?

- \_\_\_\_\_ Frequency \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ Frequency \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_ Frequency \_\_\_\_\_

#### BEHAVIOURAL ISSUES:

Potential Behaviour	Triggers / warning signs	Strategies

Any other Comments

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Case Manager: \_\_\_\_\_

Organisation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach any further comments/information that you feel will be relevant in assisting WRESACARE to provide your client with a positive, safe respite experience.**

I hereby authorise my Case Manager to forward any relevant information to WRESACARE that is required for the provision of respite services by that organisation

Signed: \_\_\_\_\_ Date: \_\_\_\_\_