skymac GROUP

ALORA RETREAT

AUSTRALIAN QUALITY CARE

ABN 33 110 787 286

ABN 21 601 714 845

CLIENT INFORMATION AND ASSESSMENT

PERSONAL INFORMATION

Last Name:

First Name:

Preferred Name:

Date of Birth:

Mobile:

Age:

Hobbies:

Likes:

Dislikes:

Diagnosis/disabilities:

Additional information (e.g., pets):

NEXT OF KIN

Name:

Relationship:

Phone Number:

Email:

Second Contact Name and Relationship:

Best Contact (email or phone number):

REFERRAL INFORMATION

Referring Agency and Name:

Email:

Phone:

CURRENT SITUATION

What is the need for Short-Term, or Medium-Term Accommodation?

NDIS

Do you have a NDIS Plan?

	Yes		No

If YES, please provide the following:

NDIS Plan Number:		Plan Dates:	

Is your plan:

	NDIS (Agency) Managed		Self-Managed		Plan Managed

If Plan Managed:

Plan Manager:	Email:	Phone:

Do you have a NDIS Support Coordinator?

	Yes		No

If YES, who is your coordinator?

Name:	Email:	Phone:

Has your Support Coordinator been informed of your stay with us?

	Yes		No

TRANSPORTATION

Do you have transportation included in your NDIS plan?

	Yes		No

Tick the boxes below if you have any of the following cards:

	Companion Card		Taxi Subsidy Card		Translink Access Card

MEDICAL CONTACTS

General Practitioner:	Email:

Address:	Phone:

Treating Hospital:	Phone:

ALLERGIES

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

MEDICAL INFORMATION

Have you had the most recent flu vaccination?

	Yes		No

If YES, please provide the date (if known):

Have you had a COVID-19 vaccination?

	Yes		No

If YES, please provide the dates of the first and second dose (if known):

First Dose		Second Dose	

Do you currently take any prescribed medication?

	Yes, medication list attached		No

Are you currently pregnant?

	Yes		No

BEHAVIOURS OF CONCERN

☐ Food-related	☐ Unintentional self-risk
☐ Eating non-food items	☐ Leaving premises without support
☐ Property damage	☐ Refusal to do things
☐ Physical aggression	☐ Repetitive or unusual habits
☐ Verbal aggression	☐ Offending behaviour
☐ Harm to self	

Comments:

Do you have a Positive Behaviour Support Plan?

	Yes, attached		No

*Ratios are determined on the level of care assessed 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

Supporting Evidence:

MY SUPPORT NEEDS

Medication	☐ Manages own medication ☐ Assistance with medication required ☐ N/A
Comments:	

Blood Glucose Level Monitoring	☐ Manages own BGL ☐ Assistance with BGL required ☐ N/A ☐ Diabetes Care Plan attached
Comments:	

Eating, Swallowing or Dysphagia	☐ I have difficulties eating, drinking, or swallowing ☐ N/A ☐ Mealtime Management Plan attached
Comments:	

Epilepsy Management	☐ Full assist ☐ Partial Assist ☐ Prompt ☐ N/A
Comments:	

Mobility	☐ Independent ☐ Walking stick ☐ Walker ☐ Wheelchair
Comments:	

Transfers	☐ Full assist ☐ Partial Assist ☐ Prompt ☐ N/A
Comments:	

Showering	☐ Full assist ☐ Partial Assist ☐ Prompt ☐ N/A
Comments:	

Toileting	☐ Continent ☐ Incontinent ☐ Use of continence aids
Comments:	

Oral Care	☐ Full assist ☐ Partial Assist ☐ Prompt ☐ N/A
Comments:	

Dressing	☐ Full assist	☐ Partial Assist	☐ Prompt	☐ N/A
Comments:				

Grooming *Hair, makeup, shaving*	☐ Full assist	☐ Partial Assist	☐ Prompt	☐ N/A
Comments:				

Assistive Technology	☐ Yes	☐ No
Comments:		

CRIMINAL HISTORY

Criminal History:

	Yes		No

If YES, please provide further information:

DRUGS AND ALCOHOL

Do you use any of the following?

Nicotine (e.g., cigarettes, tobacco)		Yes		No
Alcohol (including methylated spirits)		Yes		No
Amphetamines (e.g., speed, goey, ice)		Yes		No
Opioids (e.g., methadone, heroin, morphine)		Yes		No
Benzodiazepines (e.g., Temazepam, Diazepam)		Yes		No
Designer drugs (e.g., MDA, ecstasy, MDMA designer drugs)		Yes		No
Inhalants (e.g., glue, petrol, paint, others)		Yes		No
Others (e.g., pain killers, over the counter medications)		Yes		No

RISK OF HARM

	Suicide
I.e., Attempts, thoughts, isolation, self-harm (ask for dates).	
Comments:	

	Violence		Absconding
	Verbal abuse		Current legal matters
	Criminal history		Sexual violence
	Vulnerability		Physical aggression

Known issues relevant to behaviour (i.e., behaviour/reaction to alcohol):

REQUESTS AND CONSENTS

Medical Assistance

	Yes, I require assistance from Alora Retreat.		No, I will self-manage my medication.

By requesting assistance from Alora Retreat to assist me with my medication, I understand that:

- In accordance with Section 8 of the Residential Services (Accreditation) Regulation 2018, Alora Retreat will follow the recommended principals of the seven 'rights' for safe medication administration that have been developed within the healthcare sector and are widely used. They are:
    1. Right person
    2. Right medication
    3. Right dosage
    4. Right time
    5. Right route
    6. Right to refuse
    7. Right documentation
- 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 is authorised to store such medication safely in a locked area within the facility.
- My prescriptions can 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 are authorised to 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 may report to the appropriate people, clinics and/or medical practitioners immediately.
- Should I choose to take my medication back to my room to administer later, I do so at my own risk, and staff may notify my medical practitioner.
- 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 can notify my medical practitioner.
- Should I experience any problems with swallowing, it is my responsibility to make staff aware of these issues.
- If I experience acute or persistent swallowing problems when taking my medication, or when eating or drinking, Alora Retreat may contact my GP or health professional for assessment.

Photo Consent and Media Release

During your stay with us, Alora Retreat may take 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, image, and/or videos taken of you in such promotions?

	Yes		No

Authority to Share Information

Alora Retreat may need to collect and disclose information which is relevant to the support services provided. I understand that throughout the provision of these services, Alora Retreat may use this consent as authority to collect and disclose my information to relevant parties and agencies as requited. 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:

ACKNOWLEDGEMENT AND CONSENT BY APPLICANT

Completing this form allows Alora Retreat to assess whether we can provide the appropriate support to assist you in your everyday life. Alora Retreat may hold you accountable should incorrect information be provided. By signing below you acknowledge the information given in this form is correct.

Applicant Name:

Guardian Name:

Signature:

Signature:

Date:

Date: