

St Michaels Association Inc.

Admission Form

Office Use Only
Received _____
Sign _____

THIS FORM IS CONFIDENTIAL

Client Name _____

(please tick programmes you are applying for)

- | | |
|------------------------------------|---|
| Merton House Evening Programme | <input type="checkbox"/> Start Date _____ |
| Como Crescent Group Home | <input type="checkbox"/> Start Date _____ |
| Kenneth Court Group Home | <input type="checkbox"/> Start Date _____ |
| Desmond Wood Student Accommodation | <input type="checkbox"/> Start Date _____ |
| Community Outreach Programme | <input type="checkbox"/> Start Date _____ |
| St Michaels Assoc. Day Programme | <input type="checkbox"/> Start Date _____ |
| Respite Programme | <input type="checkbox"/> Start Date _____ |
| Units Accommodation | <input type="checkbox"/> Start Date _____ |
| Individual Support Programme | <input type="checkbox"/> Start Date _____ |
| Youth Break | <input type="checkbox"/> Start Date _____ |

Prior to the start date this Admission Form plus any other relevant documents listed below, must be completed and lodged at the office of St Michaels Association:

Drug Chart - a current, signed and dated medication chart from the doctor must be supplied for any clients that require medication while in the services of St Michaels Association.

All medication is to be packed into **Webster/Medico Packs**. This can be organised by St Michael's Association Inc in communication with the Disability Service Manager.

Clients being accommodated may be eligible for further financial assistance from Centrelink with **Rental Assistance and/or Mobility Allowance**. The office staff can assist you with completion of forms and lodgement of claims.

Desmond Wood Complex (only) - students will need to complete an AIC (Allowance for Isolated Children) form. Office staff are available to assist families in completing forms and will lodge them with the department on your behalf.

All clients' personal belongings should be named and must be insured by the family, or the client. They are not covered by St Michael's Association Inc insurance. Extending your personal insurance can do this.

Assistance with financial management is available to all clients. This can be arranged through the Disability Services Manager.

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All staff are to ensure that all information on this form is accurate and all relevant sections are complete.

All clients should have their own Medicare Card, Pension Card and / or Health Care Card and please ensure that the numbers are recorded below:

Pension Number _____ Expiry Date _____

Medicare Number _____ Expiry Date _____

Position on Card _____

Health Care Card Number _____ Expiry Date _____

St Michael's Association Inc. is to be notified of any changes to relevant information

Personal Information

Client's Surname _____

Given Name _____

Date of Birth _____

Client's Address (when not at St Michael's Association)

Postcode _____

Phone - Home _____ Mobile _____

Email _____

Religion - optional _____

Physical Description

Hair colour _____ Eye Colour _____

Height _____ Weight _____

Please attach a recent photo

Would you like your photo returned (please circle) Yes / No

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Medical Report

Upon admission into St. Michaels Association all clients are required to have a medical report completed by a family member or their practitioner prior to entry. This report is a confidential document for the undernamed applicant that will be contained in their personal file, in the office of St. Michaels Association Inc.

Immunisation Record

Item	Action	Date of last injection
Triple Antigen	Yes / No	
Sabin	Yes / No	
Measles	Yes / No	
Mumps	Yes / No	
Whooping Cough	Yes / No	
Rubella	Yes / No	
Hepatitis B	Yes / No	
Hepatitis C	Yes / No	
Tetanus	Yes / No	
Flu Vaccine	Yes / No	

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Medication Information

Is the client taking regular medications? Yes No

Under the drug administration policies a completed, signed and dated drug chart is required for all clients attending St. Michaels Association Inc.

Are there any special directions to assist with medication administration?

**Does the client have any known Drug allergies or Drug Sensitivities?
(if yes please list) Yes No**

PRN Medication - (medication that is given only when required)

PRN Medications are to administered in specific circumstances only under written directions as documented on the drug chart by the clients physician.

Does the client require PRN medication? Yes No

Medication _____
Generic Trade

Dose _____ Frequency _____

Purpose and instructions (circumstances when medication can be given, safe intervals between doses, maximum amount, when Doctor should be notified)

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Please list all medications

Medication	Dose	Time/s	Special Directions

Medical Condition/s

Does the client have any of the following medical conditions? (please circle).
If yes please attach any directions for management of the condition.

Heart condition	Yes / No	Addictions	
Diabetes	Yes / No	Tobacco	Yes / No
Epilepsy	Yes / No	Alcohol	Yes / No
Asthma	Yes / No	Other	Yes / No
Visually Impaired	Yes / No		_____
Hearing condition	Yes / No		_____
Mobility Problems	Yes / No		_____
Weight Management	Yes / No		_____
Continence	Yes / No		
Bowel condition	Yes / No		
Sleep problems	Yes / No		
Skin condition	Yes / No		
Menstrual problems	Yes / No		

Details for care of any medical condition needs to be outlined in the clients 'Health Care' Plan by their doctor

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Contact Information

Next of Kin _____

Relationship _____

Address _____

_____ Postcode _____

Phone - Home _____ Mobile _____

Email address _____

Occupation _____

Employer's Name _____

Employer's Address _____

Employer's Phone _____

2nd Contact

Relationship _____

Address _____

_____ Postcode _____

Phone - Home _____ Mobile _____

Email address _____

Occupation _____

Employer's Name _____

Employer's Address _____

Employer's Phone _____

Service Contact

Name of Service _____

Contact Person _____ Phone _____

Advocate

Contact Person _____ Phone _____

Organisation (if applicable) _____

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Guardianship

Is the client subject to Guardianship Yes / No

Name of Guardian _____

Address of Guardian _____

Phone _____ Mobile _____

Clients are assisted when attending a medical appointment as required. In case of a medical emergency the client is taken to the Launceston General Hospital or to their practitioner.

Client's Doctor _____

Doctor's Address _____

Doctor's Phone _____

After Hours Number _____

Client's Specialist (if relevant) _____

Specialist Address _____

Specialist Phone _____

Reason for specialist attention _____

Client's Dentist (optional) _____

Dentist Address _____

Dentist Phone _____

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Behaviour Management Programmes

To assist in providing consistent care to our clients we ask that you outline any behaviour management plans that may be used in the home, community or when attending other programmes.

Where possible please attached a copy of any documented management programmes.

Social Relationships

Does the client mix well with adults? YES / NO

Does the client mix well with children YES / NO

Disruptive Behaviours

Please describe any current disruptive behaviours and the strategies being used for the management of the behaviours.

Are there any factors that have been identified prior to behaviours ie: noise levels, activity, interactions from other persons, foods/drinks etc.

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Does the behaviour put the client or any other persons at risk of injury?

YES / NO

If yes, please provide details

Communication (please tick)

- Verbal
- Non – Verbal
- Signs
- Gestures

Mobility

- Walks independently
- Uses a frame
- Uses a wheelchair
 - Electric
 - Manual

Requires other aides

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Community Access

Can client travel on public services independently? Yes / No

Needs assistance getting on/off buses? Yes / No

Needs assistance paying fares? Yes / No

Needs assistance changing buses? Yes / No

Needs assistance booking taxi/wattle car Yes / No

Other (specify) _____

Comments _____

Eating Skills

Can the client eat independently? Yes / No

Clients meal size Small

Medium

Large

Food is Served Whole

Cut

Mashed

Eats Meal By self

With assistance

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Can Use

- Knife and fork
- Fork only
- Spoon
- Fingers
- Needs Assistance
- Special Bowl

Food – particular likes

Food – particular dislikes

Food – any known allergies

Diet

Does the client have any special diet? Yes / No

If yes please submit a dietary outline with this application.

Can the client eat in public places with acceptable table manners? Yes / No

Can the client order their own meals in public places? Yes / No

- Needs Assistance

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Drink

Can the client prepare and drink independently? Yes / No

Drinks from Cup/Glass
 Through Straw
 Other _____

Pours drink Assisted
 Unassisted

Boil Kettle Assisted
 Unassisted

Is the client able to carry hot drink to table? Yes / No

Please outline usual meal time routines and situation (ie: time, seating etc.)

Personal Care

Toileting

Can the client use a toilet independently? Yes / No

Needs Prompting Yes / No

Needs Assistance with clothing Yes / No

Asks to be taken Yes / No

Needs reminders to use toilet Yes / No

Recognises public facilities Yes / No

Please describe how need is indicated (words, signs, gestures)

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Does the client need to be taken/prompted to use the toilet during the day?

Yes / No

Does the client need to be taken/prompted to use the toilet during the night?

Yes / No

Does the client have toilet accidents

Never

Yes / No

Seldom

Yes / No

Only when nervous

Yes / No

Does the client wet the bed?

Yes / No

Does the client need assistance wiping after a bowel motion?

Yes / No

Is there a regular routine/time for bowel movements?

Bathing

Does the client prefer to:

Shower

Yes / No

Bathe

Yes / No

Can the client shower/bathe independently?

Yes / No

Assistance with clothing

Yes / No

Supervision only

Yes / No

Some physical assistance

Yes / No

Full assistance

Yes / No

Uses special aids (eg: shower chair)

Yes / No

Describe aid

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Hair Care

Can the client do their hair independently?	Yes / No
Assistance with applying shampoo	Yes / No
Assistance with washing	Yes / No
Assistance with rinsing	Yes / No
Assistance with brush/comb hair	Yes / No

Shaving

Electric razor	Yes / No	
Safety razor	Yes / No	
Independently	Yes / No	
Does the client require assistance with	Brushing teeth	Yes / No
	Cutting fingernails	Yes / No
	Cutting toenails	Yes / No

Dressing

Can the client dress/undress independently?	Yes / No	
Needs assistance dressing	Yes / No	
Needs assistance undressing	Yes / No	
Needs assistance choosing appropriate/clean clothes	Yes / No	
Does the client require assistance with	Buttons	Yes / No
	Shoelaces	Yes / No
	Zips	Yes / No
	Other _____	

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Can the client manage their money? Yes / No

Recognises currency Yes / No

Can count money Yes / No

Checks for correct change Yes / No

Does the client have any fears/ phobia's?

Is there any other information which you think would be helpful for the care of the client?

Individual Support Programmes

Could the clients applying for Individual Support in the home or a school please complete the following details:

Support Hours

Days of Support	Start	Finish	Location

Location Details

Home/School Address _____

Contact Person _____

Phone _____

Email _____

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Clients that accommodate at St Michaels Association will be attending a school, training or works programme during the day.

Please list below the programmes that you are currently attending.

Applicants for Accommodation MUST COMPLETE this page.

Programme 1:

Name of Programme or Service _____

Contact Person _____

Address _____

Phone _____ Mobile _____

Days attending	Times

Programme 2:

Name of Programme or Service _____

Contact Person _____

Address _____

Phone _____ Mobile _____

Days attending	Times

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Leisure Activities

Leisure/social activities can be arranged for clients to participate in provided it is at a time when staff and transportation is available.

Any costs for activities will need to be paid by the client or family. If under 16 consent must be given by the parent/guardian.

Please list any activities of interest for participation or as a spectator:

There are other Services providing a variety of evening programmes. Please tick the programmes that may be of interest

- Crossroads
- Speak out
- New Horizons
- Other _____

Agreement

Payments for accommodation and programme service fees are to be made by direct debit or at the office of St Michaels Association. Cash, cheque and Eftpos payments are accepted.

Payments can be made weekly, fortnightly or monthly.

Overdue accounts in excess of three months will be placed with a collection service and will jeopardise the continuation of services to the client.

I understand my commitment and agree to pay all accommodation and associated fees for service to St Michaels Association Inc.

Signed _____ Date _____

To be completed by parent or guardian for clients under the age of 18 years only.

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I accept that my child may choose to visit friends or relatives, or leave the St Michaels campus unsupervised, for brief periods of time and give permission for them to do so if the staff member is satisfied that they are entering a safe environment. I understand that where supervision can not be provided that my son/daughter is responsible for their actions and that any inappropriate actions or behaviours will be addressed by the staff in consultation with the **Disability Service Manager** and I will be informed of any such situation.

Signed _____ Date _____

Is there anyone that you do not give permission for your son/daughter to visit or have contact with? (in the case of a legal order could a photograph be provided to the service)

Name _____

Name _____

Name _____

Name _____

Name _____

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Marketing Permission

(Must be completed by parent or guardian if under the age of 16)

St Michael's Association Inc. is proud of its established programmes, products and services and from time to time wishes to use its greatest advertisements, its staff and clients, in promotions such as newsletters or media events.

Any advertisements, be they web pages, photographs, articles or brochures will be used purely for the promotion of the organisation and to further the organisation's objectives and purposes.

I **Do** **Do not** give permission for my child's name or photographic images to be used to promote St Michael's Association Inc, its goods and services, while I receive services from St Michael's Association Inc.

I understand that my child's name or photographic image will not be used after I leave the services of St Michael's Association Inc.

Name _____

Signed _____

Date _____

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Confidentiality

All Staff at St. Michaels Association Inc. are committed to keeping your personal information as confidential as possible according to their obligations as employees and professionals. This includes your personal details, address and contact details, family background, personal habits, medical history, or even your photograph.

Please be aware that we might be obliged to share particular information with relevant staff and volunteers, with your parent or supporter, with your medical practitioner, or with representatives of other agencies such as your Day Programme should it be requested.

In some circumstances it would be necessary for us to share certain information with other organisations such as Tasmania Police.

These issues will be discussed with you as part of your service agreement with St. Michaels Association Inc, and you will be asked to give permission for us to share certain information accordingly.

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Information Consent Form

To enable us to have a full understanding of your support needs and to be able to work in conjunction with other services to provide you with consistent support in helping you to achieve your goals we ask for your consent to contact other services, professionals or individuals involved in your care.

Please list the name of the service; a contact person and a contact number

Name of Service	Contact Person	Phone Number

The information that is collected will remain confidential within the service of St Michaels Association Inc. and will not be passed to any other persons unless consent has been given or it has been requested in an emergency.

I _____ have had this letter explained to me and agree to St Michaels Association Inc. collecting relevant information for my care from the above person/s.

Signed _____

Date _____

Witness

Print Name _____

Signed _____

Date _____

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Grievances and Complaints

We encourage clients and their supporters to, as soon as possible, report any grievances or complaints about the service provided by St. Michaels Association Inc.

Making a complaint can sometimes be confronting or upsetting. However please be assured that your comments are important to us and they will allow us to improve our services and identify hazards.

Who do I talk to about my complaint?

If you think that the problem has resulted from the actions of a staff member we encourage you to talk to the Disability Service Manager, or the CEO.

If you think the problem has resulted from the actions of a senior member of staff then we encourage you to talk to the CEO or to a member of the Board of Management.

Should I put my complaint in writing?

You may put your complaint in writing, or discuss it with one of the staff members and ask them to help write it down.

Either way we ask you to sign the complaint to confirm that you agree with the details.

Alternately you can record your concerns on tape.

You are encouraged to have a parent, guardian, advocate or other support person with you.

Will my complaint be treated confidentially?

We will keep the relevant details of your complaint as confidential as possible. However it may be necessary to discuss these details with other representatives in order to resolve the issues satisfactorily.

Such representatives may include Service Coordinators, guardians, advocates, staff members or members of the Board of Management.

What will happen after my complaint is received?

The matter will be discussed promptly with all persons involved, including yourself and the staff and representatives concerned, with the intention of seeking a prompt resolution.

We will then revise our work methods or policies to ensure that such problems will be avoided in the future.

A record will also be made to detail the date, the name of the person making the complaint, the name of the person receiving the complaint, the nature of the problem or concern, and the outcome or solution. Should you wish to view this record (or any other record kept by the organisation which relates to you) simply contact a staff member.

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What if I feel as if I have been unfairly treated?

Please tell us if you feel the outcome has not addressed your concerns, or if you otherwise feel unfairly treated. It is possible that we have misunderstood your concerns. Or have been to slow in addressing them.

If you wish you can talk to one of the members of the Board of Management to discuss your concerns.

In any case you may choose to further your complaint/s through another agency. Some of these include:

- The Department of Health and Human Services
- The Office of the Health Complaints Commissioner
- The office of the Anti-Discrimination Commissioner

Your Advocacy association may also be available to help with furthering your complaint or concern.

Client Concerns

If you have any questions or concerns there are many people available for you to talk to:

Staff

Talk to support staff, they are there to support and assist you

Family

Talk to your family for all your needs

Service Provider

Talk to your service provider they are there to address your needs whilst in their service

St Michaels - Disability Service Manager

Talk to the Disability Service Manager if you need extra help

Service Co-ordinator

Talk to your service co-ordinator they are there to help you with your needs

Advocate

You can always talk to your Advocate if no one else can help

St Michaels - Chief Executive Officer

The CEO is available to talk with you if you feel that your concerns have not been met by others

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