GETTING TO KNOW YOU

CARINYA SOCIETY

The purpose of this document is to find out as much as possible about the people who are interested in accessing Carinya's Day Service, in order to determine if Carinya can meet their needs and preferences safely.

SURNAME:	
FIRST NAME(S):	
KNOWN AS:	
DATE OF BIRTH:	
ADDRESS:	**Postcode:**

Parents / Carers:

Mr/Mrs /Ms	NAME(S) OF CARER(S)	RELATIONSHIP TO CLIENT	TELEPHONE

Siblings:

Name	Relationship to client	Age

Is there anyone that cannot have contact with you/the person?

EMERGENCY CONTACT NUMBER(S)

1st EMERGENCY CONTACT		**Number**	
2ND EMERGENCY CONTACT		**Number**	

FAMILY DOCTOR

GP'S NAME			
CLINIC NAME			
ADDRESS			
SUBURB		**P/C**	
TELEPHONE			

Is the family doctor willing to be approached while you/the person is in our care?

YES ☐ **NO** ☐

PENSION NUMBER		**EXPIRY DATE**	
MEDICARE NUMBER		**EXPIRY DATE**	
PRIVATE HEALTH FUND		**EXPIRY DATE**	
TAXI CARD NUMBER		**EXPIRY DATE**	
COMPANION CARD NUMBER		**EXPIRY DATE**	

OTHER SERVICES

NAME OF OTHER STAFF OR SERVICES			
SERVICE NAME			
ADDRESS			
SUBURB		**P/C**	
TELEPHONE			

The following information is invaluable in that it enables us to give the best possible care to you/the person. Please give as much detail as you can.

PRIMARY DISABILITY	
OTHER DISABILITIES	
HEALTH/ MEDICAL CONDITIONS	
EPILEPSY yes / no	
ALLERGIES	
Warning signs/course of action:	
Hearing – any aids	
Sight – any aids	

COMMUNICATION

How do you/does the person communicate? Please ✓

USE OF WORDS		**WRITING**	
MAKATON		**READING**	
BODY LANGUAGE		**DRAWING**	
USE OF PICTURE CARDS		**OTHER METHOD**	

Please explain fully the chosen communication method or methods.(use examples)

How do you/ does the person express feelings? (use examples)

IDENTITY

INDIGENOUS STATUS

Do you identify as being Aboriginal	
Do you identify as being Torres Strait Islander Origin	

COUNTRY OF BIRTH	
CULTURAL BACKGROUND	

LANGUAGE

English		**Cantonese**	
Italian		**Mandarin**	
Arabic		**Spanish**	
Greek			
OTHER Please specify			
LANGUAGE SPOKEN AT HOME			
IS AN INTERPRETER REQUIRED			

Would you/the person like assistance to be linked to interpreting services in your/their local community? Yes / No

RELIGION

Anglican		**Muslim**	
Atheist		**Non Practicing**	
Buddhist		**Orthodox**	
Catholic		**Protestant**	
Jehovah's Witness			

HEALTH

Are you general in good health	
If no give details	
Infections	
Course of Action	
Probable Medication	

EPILEPSY

Carinya requires a copy of your Epilepsy Management Plan to be able to effectively support you. Please provide this to Carinya prior to commencement of services.

How often do seizures occur	
Warning signs	
Triggers (noise sound light)	
What form are they	
Duration	
After effects	
Routine to aid recovery	

Is emergency medication prescribed to control the epilepsy? **YES** ☐ **NO** ☐

If yes, we must receive a copy of the Treatment Sheet. To continue receiving a service from us you must keep us informed of any changes made to your/the persons Epilepsy Management Plan

Please give exact details of medication prescribed by your /the persons doctor i.e. name of medication, dosage (amount) of medication & time to be taken each day. If rectal valium (Diazepam) or Buccal Midazolam is used please give exact details as to when and how much must be administered.

Name of Medication	Reason	Strength	Dosage	Time Due

OTHER MEDICATION

Prescribed Medication

Do you have prescribed medication	
Do you give consent for staff to administer medication as detailed on your treatment sheet	

If Yes, please indicate details on table below

Name of Medication	Reason	Strength	Dosage	Time Due

* You are responsible for keeping Carinya up to date with any changes to your/the persons medication.*

Non-prescribed medication e.g. Paracetamol, Ibuprofen

Do you have non prescribed medication	
Do you give consent for staff to administer non prescribed medication	

If Yes, which one and how much?

Name of Medication	Reason	Strength	Dosage	Time Due

How is the medication administered	Yes/ No	Please specify
Water		
Food		
Other		

MODBILITY / MANUAL HANDLING

Carinya has a No Lift Policy and requires you to support the principles of No Lift to ensure your safety and the safety of our staff.

Do you have mobility requirements	
Are you able to weight bear	
Do you have any special aid to assist with mobility Please specify below	
Do you have Manual Handling requirements	
If yes please detail	
Have you had any formal assessments **If so please attach them**	
Do you need assistance to engage a service to conduct a formal assessment	
Are you accustomed to using a hoist and sling	

SPECIALIST EQUIPMENT

Type of Equipment	Make Model Colour	Serial Number	Serviced by
Electric Wheelchair			
Manual Wheelchair			
Walking Frame			
Walking stick			
Others Please detail			
Others Please detail			

BEHAVIOUR SUPPORT

Do you have a behaviour support plan, if so please attach	
How do you behave when angry	
How can we support you when you are angry	
How do you behave when you are upset	
How can we support you when you are upset	
How do you usually behave when asked to do something	
How do you usually behave when asked to do something	
Is there a certain way we should approach instructions / requests	
How do you like people to work with you	
Do you ever behave in a manner that could cause harm to self/others	
Are there any warning signs for the behaviour described above that we should know about	
How do you react to meeting new people	

INTIMATE PERSONAL CARE

Can you complete the following ADL's

	Without support	**With some support**	**Completely unable to do**	DETAILS
Dress/Undress				
Toileting				
Eating				
Drinking				

Continence

	Completely continent	**Occasionally incontinent**	**Incontinent**	DETAILS
Continence				
	Day	**Night**	**All the Time**	
Do you use incontinence pads				

DIETARY NEEDS/ MEAL SUPPORT

Do you have a Meal Plan – (specified from a speech pathologist) if so please attach	
Do you have any special dietary needs	
Are you able to eat independently	
How much assistance is needed at mealtimes	
What kind of plate , dish and cutlery do you use	
Does Food need to be	
Cut , chopped mashed , liquidised.	
Do you required feeding by a Gastrostomy Tube	
If yes please detail methods, times, and procedure	

LEISURE/ COMMUNITY ACCESS

What I enjoy the most	
What I don't enjoy	
I have the following pets	
I love these sports	
My favourite games	
My favourite music	
My favourite things to do in the community	
Do you like to go for walks	
How do you feel or present when shopping	
I can use stairs **I can use escalators**	
How do you feel or present when on public transport	
Do you tire easily	
Can you swim	
If so how independent am I in the pool	
What is important to me ??	
I have these fears & phobias	

Thank you for completing this questionnaire. Please sign in space provided below to acknowledge you accept the contents of this document and have received a copy.

Signature of Person: …… **Date:** ……..

Signature of any other people involved in assisting with the completion of this questionnaire

Signature…….... **Date:** ……..

Signature…… **Date:** ……..