ESCAPADES

PARTICIPANTS DETAILS

Who is supplying this information?

☐Self ☐Family member ☐Other Professional…………………………

PARTICIPANTS DETAILS	
Name	
Address	
Home Phone/ Mobile	
Date of Birth	
Email	
Religion	

NEXT OF KIN	
Name	
Relationship	
Home Phone	
Mobile	
Email	
KEY CONTACTS	
Name	
Relationship	
Home Phone	
Mobile	
Email	
OTHER EMERGENCY CONTACTS	
Name of Contact	
Address	
Phone	
Relationship	

NDIS NUMBER				
NDIS REVIEW DATE				
SERVICE WANTED	TICK	DAYS	FREQUENCY	SHORT NOTICE AVAILABILITY
WAK				
GROW WITH US				
SOUL SUPPORT				
SLES				

ESCAPADES

ESCAPADES
grow with us

GP CONTACT		
Doctor's Name	Doctor's Address	Doctor's Phone Number
OTHER SPECIALISTS		
Name	Speciality	Contact

WHAT DO YOU DESCRIBE YOUR DISABILITY AS?
ANY THING ELSE WE NEED TO KNOW ABOUT YOUR DISABILITY?

HOUSING PROVIDER INFO		
Organisation Name	Contact Name and Number	End of lease

WHAT WOULD YOU LIKE US TO KNOW ABOUT YOU?

ESCAPADES

PARTICIPANTS LIKES

PARTICIPANTS DISLIKES

ANY OTHER INFORMATION WE SHOULD KNOW TO ASSIST US TO SUPPORT YOU?

ESCAPADES

ESCAPADES grow with us

LIFESKILLS SUPPORT*delete as required

DAILY LIVING SKILLS

☐Cooking ☐Cleaning ☐Shopping ☐Paying bills

Details:____

____

TRANSPORT

☐Support to travel

☐Support to learn public transport

☐Support to learn how to drive

Details:____

____

ADMINISTRATION

☐Support with other organisations i.e. Public Trustee

☐Support to complete paperwork

Details:____

____

HEALTH

☐Support to make/attend medical appointments

☐ Support to care for my health needs

Details:____

____

OTHER APPOINTMENTS

☐Support to make/attend other appointments

Details:____

____

OTHER LIFESKILLS SUPPORT REQUIRED

____

____

____

____

____

____

____

ESCAPADES

PERSONAL CARE SUPPORT *delete as required

MOBILITY

☐Independent
☐Independent with aids (aids e.g. wheelchair)
☐Assistance required with walking ☐Full ☐ Partial ☐Verbal Prompts
☐Assistance required with aids/wheelchair ☐Full☐Partial ☐Verbal Prompts
Details: ____
____

TRANSFERS

☐Aids –Cane/ walker/wheelchair
☐Assistance required with transfers: ☐Full☐ Partial ☐Verbal Prompts
☐Can transfer with assistance of at least one (1) person (may include use of lifting device)
☐Can transfer with assistance of at least two (2) people (with use of a lifting machine)
Details: ____

PERSONAL HYGIENE – BATH/SHOWER

☐Independent
☐Assistance required with bathing/showering ☐Full ☐ Partial ☐Verbal Prompts
Details: ____

DRESSING

☐Independent
☐Assistance Required ☐Full ☐ Partial ☐Verbal Prompts
Details: ____

GROOMING (includes shaving)

☐Independent
☐Assistance Required ☐Full ☐ Partial ☐Verbal Prompts
Details: ____

TOILETING

☐Independent
☐Assistance required ☐Full ☐ Partial ☐Verbal Prompts
☐UrineIncontinence
☐FaecalIncontinence
Details: ____
____

ESCAPADES

PERSONAL CARE SUPPORT*delete as required

TEETH BRUSHING

☐Independent
☐Assistance Required ☐Full ☐ Partial ☐Verbal Prompts
Type of Toothbrush: ☐Electric ☐Hand Held
Details: ____
____

EATING

☐Independent
☐Assistance Required ☐Full ☐ Partial ☐Verbal Prompts
☐Tube Feed Only
☐Vitamised food

State what assistance is needed e.g. cut up meat, setting up, etc.___________________________________
____

DIETARY REQUIREMENTS

Special diet required
____
____
____
____

Allergies
____
____
____

Preferred food/ food dislikes
____
____
____

OTHER SUPPORT REQUIRED

____
____
____
____
____
____
____
____

ESCAPADES

HEALTH INFORMATION*delete as required

VISION(refers to client's ability with glasses if normally worn)

☐Has no visual impairment
☐Has limited vision, difficulty seeing and identifying large objects (cups, etc.)
☐Has no vision
☐Wears Glasses
Details: ____

HEARING(rate with hearing aids on, if normally worn)

☐Has no hearing impairment
☐Hears loud sounds and voices only
☐Has no hearing
☐Wears hearing aids
Details: ____

COMMUNICATION circle the current forms of communication

☐Verbal ☐Photographs ☐Written ☐Communication Book
☐Visual ☐Auslan
Details: ____

SPEECH/COMPREHENSION(includes lack of common language, speech or cognitive disorder)

☐No speech/comprehension difficulties
☐Has speech difficulties (e.g. SLI)
☐Has comprehension difficulties
☐Has little/no speech- Non verbal
☐Has limited comprehension
Details: ____

SENSORY DIFFICULTIES

☐Has no sensory issues
☐Has visual sensory difficulties- details below
☐Has touch sensory difficulties-details below
☐Has hearing sensory difficulties- details below
Details: ____
____

ESCAPADES

HEALTH INFORMATION*delete as required

Who is giving this information?

☐Self ☐Family member ☐Report☐Other Professional………………………

Do you have any health condition that we should know about?			
	Yes	**No**	**Details**
Allergies			
Anxiety			
Asthma			
Attention Deficit Disorder			
Depression			
Diabetes/low blood sugar			
Dietary Needs			
Epilepsy/seizures			*Seizure plan required*
Mental Illness			
OCD			
ODD			
Other			

Any participant who requires medication to be either given or checked by Escapades Group staff must have a medication authority form signed off by their G.P and relevant documentation for guidance on supporting you with your health issue for example a seizure plan.Medication should be labelled with your name/address/ dosage or in a webster pack.

MEDICATION	WHEN	BY WHOM	MULTI DOSE PACK

ESCAPADES

COMMUNITY ACCESS*delete as required

EMPLOYMENT	
Are you currently working	Y / N
Employer Name	
Address	
Contact Name/ Number	
When (circle days)	M T W T F SAT SUN From to

DAY SERVICE	
Are you currently attending Day service	Y / N
Name	
Address	
Contact Name/ Number	
When (circle days)	M T W T F SAT SUN From to

SOCIAL ACTIVITIES		
Club Name	Address	When
		M T W T F SAT SUN From to
		M T W T F SAT SUN From to
		M T W T F SAT SUN From to
		M T W T F SAT SUN From to

WHO LOOKS AFTER YOUR MONEY?

☐Self ☐Family ☐Escapades Group Staff
☐ Friend ☐Public Trustee ☐Other organisation staff

FINANCIAL SUPPORT DETAILS

OTHER HELPFUL INFORMATION	
Medicare Number	
Healthcare card number	
Private Health care number	
Disability Support Pension number	
Companion card number	
Other association's/memberships	
Cab voucher number	

ESCAPADES

KEEPING EVERYONE SAFE*delete as required

Who is giving this information?

☐Self ☐Family member ☐Report ☐Other Professional………………………………

BEHAVIOUR SUPPORT	Y/N	DETAILS	REPORT ATTACHED
When you get upset or worried do you become verbally abusive to others?			
When you get upset or worried do you become physically abusive to others?			
When you are upset or worried do you hurt yourself?			
When you get upset or worried do you cause damage to property?			
Are you prone to changing moods? If so, how frequently & any triggers?			
Are there any concerns around people of the opposite sex?			
Are there people in your life who could put you or staff at risk?			
Are there any legal orders restricting access/contact with anyone?			
Do you have any addiction issues?			
Do you smoke cigarettes?			

BEHAVIOURSUPPORT INTERNAL USE ONLY

☐No behaviour support needed
☐Behaviours of concern-further information to be sourced
☐No risk management plan required
☐Risk management plan to be developed

ANY OTHER INFORMATION RELATING TO KEEPING YOU SAFE?

ESCAPADES

CONSENT FOR TAKING AND USING YOUR PHOTO

Please give your consent to getting your photo taken

We want to take photos to use in marketing material like brochures and our website.

The photos will be used to tell other people about what we do and how we do it.

Your photo might be featured on our website or on some of the pamphlets and brochures we use.

We need your consent to take your photo and to show your photo.

CONSENT FORM:I, ……………………………(write your name here)

My photo can be taken

☐ YESNO ☐

My photo can be used by Escapades Group

☐ YES ☐ NO

SIGNED: ……………………………………………………………………DATE: ……………………………………

PARENT / GUARDIAN / ADVOCATE

SIGNING CONSENT ON BEHALF OF: ………………………………………

PARENT / GUARDIAN / ADVOCATE NAME: ……………………………………………………………………..

SIGNED: …………………………………………………………………… DATE: ……………………………………

ESCAPADES

ESCAPADES CONSENT FORM

Please ensure that all permission requests are acknowledged and signed

1.Medical Permission

(a) A medical practitioner to administer any medical assistance to my child in an emergency

Yes ❑ No❑

(b) My child to be given a blood transfusion in the case of an emergency

Yes ❑ No❑

(c) Escapade staff to obtain medical assistance, which they deem necessary and I agree to pay all Ambulance, medical and dental expenses incurred on behalf of the participant

Yes ❑ No❑

If you answered no to any of the above, please give details: ______________________________

____

____

2. Medication

For the medication(s) as recorded to be administered to the participant in accordance with medical practitioner's instructions by an Escapade staff member trained and accredited in medication administration

Yes ❑ No❑

3. Illness before and /or during group activities

As parent/guardian I agree that if my child has any contagious illnesses such as chicken pox, whooping cough or heavy flu I will not send them into the program and I will contact Escapades to advise them of this. If my child becomes ill whilst during their Community Access Program, I agree to meet staff and pick my child up as soon as possible

Yes ❑ No❑

4. Community Access

I give permission for my child to be transported by any of the Escapade staff in their van or car to access the community for outings, sports functions, movies etc.

Yes ❑ No❑

5. Swimming

s a parent/guardian I give my consent for my child to participate in swimming or aquatic activities and agree to the delegation of authority to the staff and/or instructors involved.

Yes ❑ No❑

ESCAPADES

6. Photo's/ Video's

As a parent/guardian I give my consent for photos and videosof my child to be taken to be used at the discretion of Escapades on their cameras to be shared with family/carers.

Yes ❑ No❑

7. Group Allocation

As the parent/guardian I am aware that my child/ren may be allocated into a group of other participants who are aged between 6-25 years of age.

This process will be considering the following considerations:

- The best interest of my child will be paramount
- Age difference of participants
- My child's ability

Yes ☐ No☐

8. People with permission to pick up my child

As parent/guardian I give my consent for the following people to pick up my child from Escapades Community Access program

Name: ________________________**Relationship:** _______________**Number**_________________

Name: ________________________**Relationship:** _______________ **Number**_________________

9. Inappropriate behaviour

If my child displays inappropriate behaviour whilst in the community such as being verbally or physically abusive towards others and they refuse to take instruction from Escapades staff and/or put them selves and/or others at risk, I agree to come and pick my child up from a negotiated point as soon as possible.

Yes ☐ No☐

As _________________________________ **parent/ guardian/ nominee I agree to the above**

Name: _______________________________________**Date:** ______________________

Signature: ____________________________________

ESCAPADES

CONSENT FOR SHARING YOUR INFORMATION

Escapades Group will only use information about you with your consent.
Consent means that you have said yes.

We use this tick to show you have said yes.

We use this cross to show you have said no.

Your name: ______________________________ This date: ______________

Who is helping you with this form? __________________________________

Consent needs to be checked at least each year.

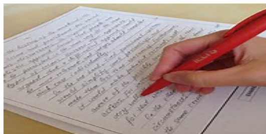
Next consent due by: _________________

We want to be able to give you the best support service we can.

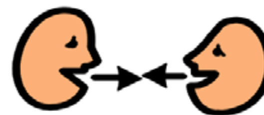
Sometimes we need to be able to get information about you from other people.

Sometimes other people want to be able to get information about you from us.

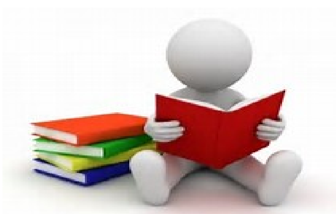
For example-Your doctor might want to get some information from us to help care for you better.   Sharing of information may include



Writing about you



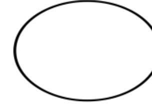
Talking to someone about you



Reading information about you

ESCAPADES

PLEASE PUT A CIRCLE AROUND YOUR ANSWER LIKE THIS



Yes	No	People we can share info with
✓	✗	Your Doctor
✓	✗	People who help you with your health and wellbeing: Your physio, Your podiatrist,Your Gym
✓	✗	Your Mum Your Dad
✓	✗	Your sister,Your brother, Your grandparents
✓	✗	Disability Services SA Your case worker
✓	✗	ndis
✓	✗	Your Public Trustee
✓	✗	Your friends
✓	✗	Your housing provider
✓	✗	Your school
✓	✗	

If we believe you are at risk of hurting yourself or others we may have to share information about you to keep you safe, even if you have not given consent.

Name: ___________________________ Date: __________________________

Signed: __________________________

If I am not able to give my own consent: My guardian or my advocate will sign this form.

Name: ___________________________ Date:__________________________

Signed: __________________________

ESCAPADES

I agree that the information given by me for this intake form is correct and accurate to the best of my knowledge.

SIGNATURES

PARTICIPANT

Name: ____

Signature: ____ Date:_____/_____/_____

PARENT/CAREGIVER/GUARDIAN IF APPLICABLE

Name: ____

Relationship: ____

Signature: ____ Date:_____/_____/_____

ESCAPADES GROUP COORDINATOR

Name: ____

Signature: ____ Date:_____/_____/_____

REVIEW DUE: ________________________