

Services for older people

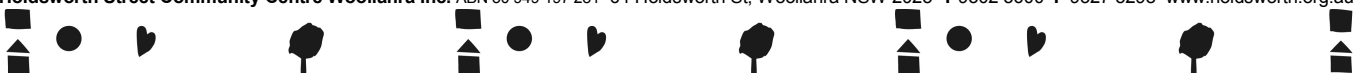
Participant Information and Emergency Contact Details

Phone: 9302 3600 E-mail: intake@holdsworth.org.au Web site: www.holdsworth.org.au

Full Name:		Date Of Birth:	
Address: <i>(Include postal address if different)</i>			
Telephone/Mobile:		E-mail:	
Main language: Spoken at home		Are you Aboriginal or Torres strait Islander?	Please Circle YES NO
Country of birth:			
Cultural or Religious Affiliations:		Publicity Consent for our newsletter	Please Circle YES NO

Emergency Contact/s:			
1) Name:		Telephone: Mobile: Work: Relationship:	
2) Name:		Telephone: Mobile: Work: Relationship:	
Doctor (GP) Contact:			
3)Name:		Telephone: Mobile:	

Medical Information & Health Profile: <i>(Medical Conditions we should know about)</i>			
Medications: <i>(Do you need staff to remind you to take medicine?)</i>		Dosage:	
Allergies:			



In this section please specify any other information that we may need to be aware of- **Dietary requirements** or religious/cultural holidays etc.

Name of person completing this form: _____
 Contact No: _____

Please tick the types of services you would like to receive from Holdsworth Aged Services:

- | | |
|---------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Individual Transport | <input type="checkbox"/> Assisted Shopping Program (CLASP) |
| <input type="checkbox"/> Healthy Ageing Programs (Yoga) | <input type="checkbox"/> Saturday Night Program |
| <input type="checkbox"/> Outings & Social Groups | <input type="checkbox"/> Low Vision Friendship Group |
| <input type="checkbox"/> Memory Loss Social Groups | <input type="checkbox"/> Movie Matinee |
| <input type="checkbox"/> List Shopping | <input type="checkbox"/> Discussion Group |
| <input type="checkbox"/> Shopping Bus | <input type="checkbox"/> Music Appreciation Club |
| <input type="checkbox"/> Companion Home Visits | <input type="checkbox"/> Woollahra Link (Community Bus) |

Do you own your own home? YES / NO (please circle)

Do you live: Alone With Spouse or Partner With Relative or Other

Are you receiving Pension? YES / NO (please circle)

What type of Pension: Aged Disability Vet Affairs

Do you use aid for mobility? (Please circle)

NO WALKING STICK WALKING FRAME OTHER MOBILITY AIDS _____

Please tick tasks that you CANNOT DO on a daily basis independently.

Grocery Shopping
 House Work
 Minor Home Maintenance

Bank/Pay Bills
 Prepare meals
 Access Public Transport

Shower Yourself
 Dress Yourself
 Use a Telephone



How did you hear about Holdsworth Community Centre & Services:

- Friend Web Site Newsletter Other Organisation/name: _____
 Doctor Other (please specify) _____

I, _____ **(Client/ Carer)** state that information given to Holdsworth Community Centre & Services, Woollahra is true and correct. And I understand that all information provided will remain private and confidential.

Please Sign 

Signature _____ **(Client/Carer)** Date _____

Signed _____ Date _____

(Person undertaking assessment on behalf of Holdsworth)

Memory Loss Programs Only - to be completed by the carer:

<u>Personal Care:</u>	
<u>Behaviour:</u>	
<u>Strategies for Management:</u>	



