ESCAPADES

Policy Area	Privacy Policy
Policy	E-17
Approval Date	02 November, 2023
Review Date	31 October, 2026

PARTICIPANTS DETAILS

Who is supplying this information?

☐ Self ☐ Family member ☐ Other Professional……

PARTICIPANTS DETAILS		
Name		M/F
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**
COMMUNITY ACCESS PROGRAM SCHOOL HOLIDAY PROGRAM					
B & A School Care Program					
DAY OPTION PROGRAM					
RESPITE PROGRAM					

GP CONTACT		
Doctor's Name	**Doctor's Address**	**Doctor's Phone Number**

OTHER SPECIALISTS		
Name	**Speciality**	**Contact**

WHAT DO YOU DESCRIBE YOUR DISABILITY AS?
Do You have a Positive Behaviour Support Plan? Y/N If Yes, can you please provide your Positive Behaviour Practitioner details
In your Positive Behaviour Plan, does it state that you require any of the following Restrictive Practices
Environmental Mechanical Chemical
Seclusion Physical

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

WHAT WOULD YOU LIKE US TO KNOW ABOUT YOU?

PARTICIPANTS LIKES

PARTICIPANTS DISLIKES

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

LIFE SKILLS 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

_____

_____

_____

_____

_____

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: _____

_____

PERSONAL CARE SUPPORT *delete as required

TOILETING

TOILETING

☐ Independent

☐ Assistance required ☐ Full ☐ Partial ☐ Verbal Prompts ☐ Urine Incontinence ☐ Faecal Incontinence

Details: _____

_____

TEETH BRUSHING

☐ Independent

☐ Assistance Required ☐ Full ☐ Partial ☐ Verbal

Prompts Type of Toothbrush: ☐ Electric ☐ Handheld

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

_____
_____
_____
_____
_____
_____

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 ☐ Has comprehension difficulties ☐ Has little/no speech- Nonverbal ☐ 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: _____
_____

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			Asthma plan required
Attention Deficit Disorder			
Depression			
Diabetes/low blood sugar			
Dietary Needs			
Epilepsy/seizures			*Seizure plan required*
Mental Illness			
Obsessive-compulsive Disorder			
Oppositional defiant Disorder			
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

MEDICATION CONSENT

I _____ (parent or guardian) give permission to staff member/participant/parent to self-administer/administer medication as indicated above for _____ (participant name) while attending Escapades Group Pty Ltd Programs.

_____ _____

Parent/Guardian Signature **Date**

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	

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?			

BEHAVIOUR SUPPORT 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?

CONSENT TO TRANSPORT (F-20)

ESCAPADES requests consent to transport your child/adult as per the details below.			
NAME OF PROGRAM			
Contact Details of the Child and the Parent/ Guardian Providing Authorisation			
CHILD'S/ADULT'S NAME:			
PARENT/GUARDIAN NAME:			
ADDRESS:			
SUBURB:			
POSTCODE:		MOBILE:	
Nominated Emergency Contacts (where parent/ guardian is not contactable)			
FIRST CONTACT (NAME):			
RELATIONSHIP:			
HOME PHONE:		MOBILE:	
SECOND CONTACT: (NAME)			
RELATIONSHIP:			
HOME PHONE		MOBILE:	

- I give consent for my child/Adult to be transported by ESCAPADES as detailed above.
- I agree that the ESCAPADES staff may take necessary steps to ensure the safety and wellbeing of all children, /adults including establishing with my child/adult individually or in the group any boundaries for appropriate conduct.
- In the event of an accident or illness and where contact with me is impracticable or impossible, I authorise the ESCAPADES staff to arrange whatever medical or surgical treatment a registered medical practitioner considers necessary. I will pay all medical and dental expenses incurred on behalf of my child/adult.
- I have also provided health care information, including details of any additional health support he/she requires. I also consent to my child's/adult's doctor or medical specialist being contacted in an emergency.

The information given is accurate to the best of my knowledge.

NAME:

SIGNATURE: **DATE:**

NUTRITION AND SWALLOWING CHECKLIST

PARTICIPANT

Name: _____ Male □ Female □

Date of Birth: _____ Age: _____

Address: _____ Postcode: _____

This address is:
An independent residence ……..□
A family home ……..□
A group home ……..□
A SIL Accommodation ……..□
Other (specify) ……..□

Has the Nutrition and Swallowing Checklist been sued before for this participant? Yes/No

I yes, when? Date: _____

PERSON CONDUCTING THE CHECKLIST

Date checklist is completed: _____

Name (Person completing the checklist): _____

Your relationship to the participant:
Parent ……..□
Service Coordinator ……..□
Team Leader ……..□
Allied Health (Specify) ……..□
Other (Specify)……..□

How long have you know the participant:
Less than 6 months……..□
6 months to 1 year ……..□
1-2 years……..□
2-5 years ……..□
More than 5 years ……..□

Weight Information

Current weight without shoes: ……..kg Date weighed: ……..

Weight change over the past 3 months: ……..kg Gained □ Lost □

Height information

Current height (measured standing and without shoes) ……..cm Date measured: ……..

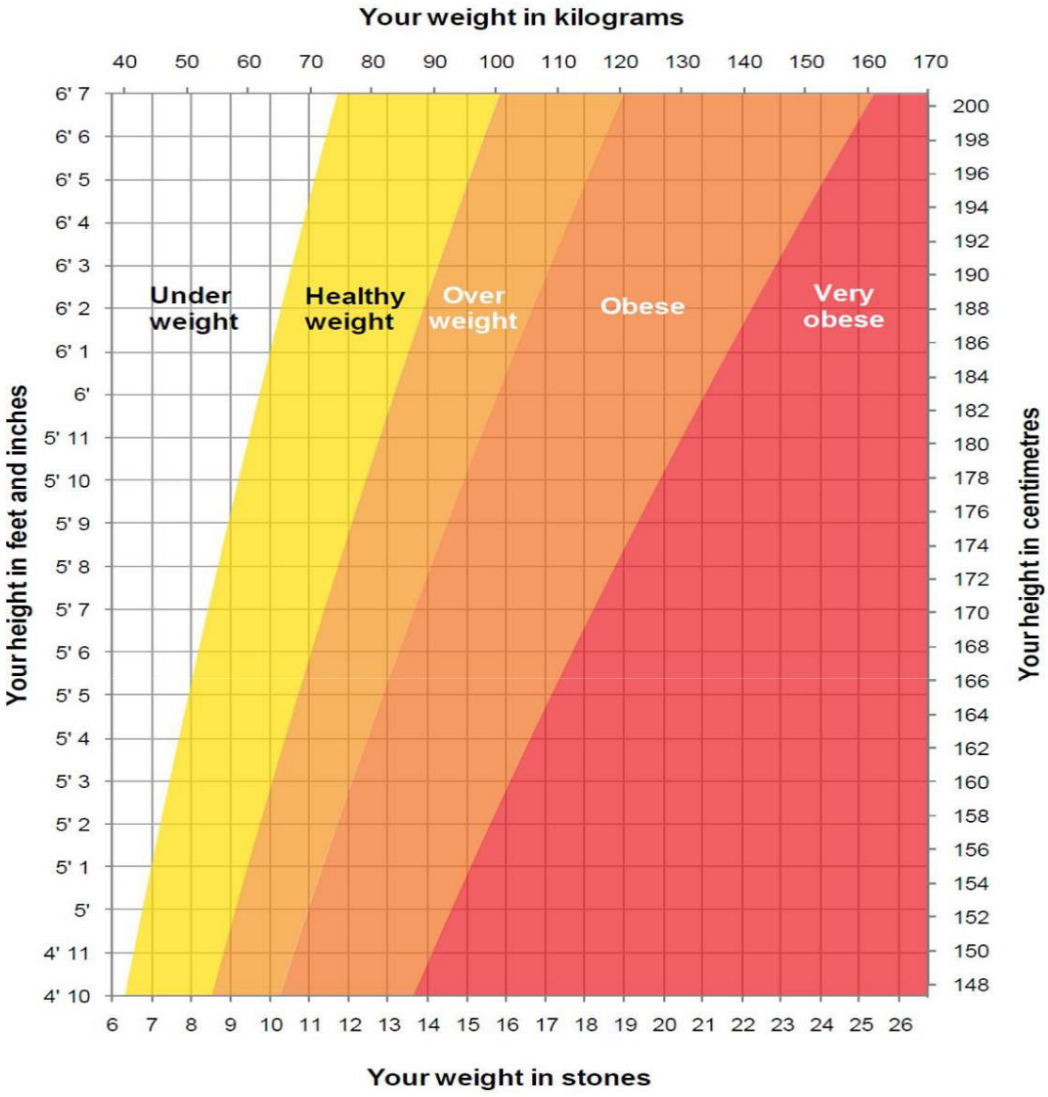
Note: For children and young people under 18 years, their growth rate should be assessed by a GP, paediatrician, early childhood nurse or dietitian every.

Has this happened? Yes□ No□

Using the weight and height information

If the person is an adult, mark the spot on the chart (below) where their height and weight meet.

WEIGHT FOR HEIGHT CHART
(FOR MEN AND WOMEN FROM 18 YEARS ONWARD)



NUTRITION AND SWALLOWING RISK CHECKLIST	
Please tick a box for each question. The explanation beneath each question will help you complete the checklist.	
Q.1 If the participant is a child (under 18 years) have they lost weight or failed to gain weight over the last 3 month? *You will need weight records to answer this question accurately*	Yes □ No □ Unsure/Don't Know □
Q.2 Is the participant underweight? *Tick the YES box if either of the following apply:* • *They are an adult and their weight on the Weight for Height Chart is in the very underweight range* • *When you look carefully at the participant (adult or child), their bone structure is easily defined under their skin. This can indicate significant loss of fat tissue and is easily checked by looking around the eyes and cheeks. Other areas to check include the shoulders, ribs and hips*	Yes □ No □ Unsure/Don't Know □
Q.3 Has the participant had unplanned weight loss or have they lost too much weight? *Tick the YES box if any of the following apply:* • *Their weight loss is undesirable or has been unexpected* • *They are under 18 years and there is any weight loss in two or more consecutive months* • *They have lost weight on two or more consecutive months and are not on a monitored weight loss program*	Yes □ No □ Unsure/Don't Know □
Q.4 Is the person overweight? *Tick the YES box if either of the following apply:* • *They are an adult (over 18 years) and their weight on the Weight for Height Chart is in the overweight or obese range* • *They (adult or child) appear to have rolls of body fat, e.g. around the abdomen*	Yes □ No □ Unsure/Don't Know □
Q.5 Has the person had unplanned weight gain or have they gained too much weight? *Tick the YES box if either of the following apply:* • *Their weight gain is undesirable or has been unexpected* • *They are not on a weight gain program and their clothes non longer fit*	Yes □ No □ Unsure/Don't Know □
Q.6 Is the participant receiving tube feeds? *Tick the YES box if the participant is receiving naso-gastric, naso-duodenal or gastrostomy feeding*	Yes □ No □ Unsure/Don't Know □
Q6a If you answered Yes to question 6, does the participant also receive food or drink through the mouth? *Tick the YES box if they receive any food or drink by mouth, in addition to tube feeding*	Yes □ No □ Unsure/Don't Know □
If the participant is receiving tube feeds and no other food by mouth, then answer only questions 10, 13, 14, 16, 18 and 19	

Q.7 Is the participant physically dependent on others in order to eat or drink? *Tick the YES box if:* • *The participant cannot put food or drink into their own mouth and someone else is needed to feed them*	Yes □ No □ Unsure/Don't Know □
Q.8 Has the participant had a reduction in appetite or food or fluid intake? *Tick the YES box if either of the following apply:* • *They are not eating or drinking as much as they usually do and this is unintentional* • *They appear unwilling to take most food offered to them and the equivalent of 6 large glasses of fluid each day*	Yes □ No □ Unsure/Don't Know □
Q.9 Does the participant follow or are they supposed to follow a special diet? *Tick the YES box if they are on or are supposed to be on any of the following dietary plans:* • *Puree, minced, chopped or soft foods* • *Thickened fluids* • *Weight reduction or weight-increasing* • *Low fat* • *Vegetarian* • *Low Cholesterol or cholesterol-lowering* • *Diabetic* • *Any other diet which modifies or restricts foods or food choices*	Yes □ No □ Unsure/Don't Know □
Q.10 Does the participant take multiple medications? *Tick the YES box if:* • *They are usually on more than one type of medication*	Yes □ No □ Unsure/Don't Know □
Q.11 Does the participant select inappropriate foods or behave inappropriately with food? *Tick the YES box if any of the following apply:* • *They are a "picky" eater or refuse to eat some food groups, making a balanced diet impossible* • *They over-consume alcohol or coffee, tea and cola drinks* • *They eat non-food items such as dirt, grass or faeces* • *They drink excessive amounts of fluid* • *They steal or hide food*	Yes □ No □ Unsure/Don't Know □
Q.12 Does the participant usually exclude food from any food group? *Tick the YES box if the participant usually excludes all goods from one or more of the following groups of food:* • *Bread, cereals, rice, pasta, noodles* • *Vegetables, legumes* • *Fruit* • *Milk, Yoghurt, Cheese* • *Meat, fish, poultry, eggs, nuts, legumes*	Yes □ No □ Unsure/Don't Know □
Q.13 Does the participant get constipated? *Tick the YES box either of the following apply:* • *Their bowel movements are irregular, painful and sometimes infrequent* • *Laxatives, suppositories or enemas are required to maintain regular bowel movements*	Yes □ No □ Unsure/Don't Know □
Q.14 Does the participant have frequent fluid-type bowel movements?	Yes □ No □ Unsure/Don't Know □

Q.15 Does the participant have mouth or teeth problems that affect their eating? *Tick the YES box if any of the following apply:* • *Teeth are loose, broken or missing* • *The lips, tongue, throat or gums are red and inflamed or ulcerated* • *They have a malocclusion (upper and lower teeth do not meet) and this affects their ability to chew*	Yes □ No □ Unsure/Don't Know □
Q.16 Does the participant suffer from frequent chest infections, pneumonia, asthma or wheezing? *Tick the YES box if any of the following apply:* • *They have had frequent chest infections or pneumonia* • *They are usually "chesty" or have difficulty clearing phlegm* • *They have asthma or wheeze*	Yes □ No □ Unsure/Don't Know □
Q.17 Does the participant cough, gag and choke or breathe noisily during or after eating food, drinking, or taking medication? *Tick the YES box if any oof the following apply:* • *They sometimes cough or choke during or several minutes after eating, drinking or taking medication* • *Their breathing becomes noisy after eating or drinking or while talking* • *They gag on eating, drinking or taking medication*	Yes □ No □ Unsure/Don't Know □
Q.18 Does the participant vomit or regurgitate on a regular basis? **(Note: This question is not applicable to infants under 12 months of age)** *Tick the YES box if either:* • *They vomit or regurgitate (i.e. bring up) food, drink or medication more than once per day or on a regular basis* • *They take anti-reflux medication* • *They clear their throat often or burp often*	Yes □ No □ Unsure/Don't Know □
Q.19 Does the participant drool or dribble saliva when resting or eating or drinking? *Tick the YES box if either of the following apply* • *The person drools or dribbles saliva at rest or mealtimes* • *Their clothes or protective napkins/bibs frequently need changing because of drooling*	Yes □ No □ Unsure/Don't Know □
Q.20 Does food or drink fall out of the participant's mouth during eating or drinking? *Tick the YES box if any of the following apply:* • *They are unable to close their mouth and this causes food, drink or medication to fall out of their mouth* • *They cannot keep their head upright and food, drink or medication falls out of their mouth* • *Their tongue pushes food, drink or medication out of their mouth* • *Their mouth continuously needs to be wiped or they need to wear a cloth to protect their clothes during mealtime* **Note that this question does not relate to the participant's manual dexterity or ability to place food in their mouth.**	Yes □ No □ Unsure/Don't Know □

Q.21 If the participant eats independently, do they overfill their mouth or try to eat very quickly? *Tick the YES box if they eat independently and any of the following apply:* • *They try to cram or "stuff" their mouth before attempting to chew or swallow* • *They try to swallow too much food before they have chewed it properly* • *They usually finish all of their main meal in less than 5 minutes*	Yes □ No □ Unsure/Don't Know □
Q.22 Does the participant appear to eat without chewing? **(Note: This questions does not apply to participants on a puree diet)** *Tick the YES box if any of the following apply:* • *They suck their food instead of chewing* • *The food remains in the mouth for a long period of time before swallowing* • *They swallow their food whole without chewing*	Yes □ No □ Unsure/Don't Know □
Q.23 Does the participant take a long time to eat their meals? *Tick the YES box if either of the following apply:* • *They eat independently and they take more than 30 minutes to eat meals* • *They are dependent on someone to feed them and it takes a long time to feed them the whole meal* • *They appear to tire as the meal progresses and may not finish their meal*	Yes □ No □ Unsure/Don't Know □
Q.24 Does the participant show distress during or after eating or drinking? *Tick the YES box if any of the following apply* • *They appear distressed while they eat or drink* • *They appear distressed immediately after or shortly after eating or drinking* • *Sometimes while distressed they refuse food or spit out food*	Yes □ No □ Unsure/Don't Know □

If you answered YES to one or more questions, the participant may have a nutrition risk or risk to safe swallowing.

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 SERVICES COORDINATOR

Name:

_____

Signature: _____ Date:_____/_____/_____

REVIEW DUE: _____

ESCAPADES GROUP DIRECTOR

Name:_____

Signature:_____Date:_____/_____/_____