

HOLROYD PEER SUPPORT PROGRAM MEMBERSHIP FORM.

This information is confidential. The client may view their personal file by arrangement with the Coordinator.

Date:..... Name of assessor:.....

Surname:..... Given names:.....

Date of birth:..... NESB:.....

Address:.....

Home telephone:..... Work telephone:.....

Who do you live with?.....

Your disability?.....

Emergency contact

Name:..... Name:.....

Address:..... Address:.....
.....

Home phone:..... Home phone:.....

Work phone:..... Work phone:.....

Relationship:..... Relationship:.....

Medication

Medication	Dosage	Administration

Medical Information

Do you need help taking your medication?.....

Allergies:.....
.....

Doctor's name & address:.....
..... Phone:.....

Additional information:.....
(diabetes, epilepsy etc?).....

Do you use any special aids or equipment?.....
.....

Health care card no:..... Medicare no:.....

Personal information

Do you need help with: **toileting** **eating** **dressing**
(please circle)
 traffic **money** **reading**

or anything else?.....

Additional info:.....
.....

Are you scared of anything?.....
(dogs, the dark, crowds, etc).....

Do you prefer to go out **alone** or **with one other person** or
with a group?.... (please circle)

Would you prefer to go out **at night** or **in the daytime** ? (please circle)

Are you able to travel by public transport by yourself? **Yes** **No**

Would you like activity information sent to you on tape? **Yes** **No**

Do you need an interpreter to assist with your bookings? **Yes** **No**

Additional comments:.....
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