Client Assessment Profile – Privacy Consent

Gold Coast Recreation & Sport Inc recognises and respects each person's right to privacy, dignity and confidentiality.

This consent applies to all Gold Coast Recreation & Sport Inc clients, volunteers, employees, donors and business partners.

The primary purpose for collecting personal information from you is to provide safe and effective delivery of services, and for purposes which are related to our functions and activities.

Gold Coast Recreation & Sport Inc will disclose your personal information to Gold Coast Recreation & Sport Inc employees and volunteers in order to provide safe and effective support. Gold Coast Recreation & Sport Inc may also disclose relevant personal information to other external organisations including:

Allied health and other services
Ashmore PCYC
Crossroads Gold Coast
Gold Coast PCYC
Government Departments who provide funding and support to GCRS.
Nerang PCYC
Sailability Gold Coast Inc.
Sailing Gold Coast Inc.

Your personal information may also be used to identify additional supports, programs or services that may be relevant to your individual situation. This information and communication can include:

- Gold Coast Recreation & Sport Inc newsletter
- Invitation to support groups and community networks
- Notification of Gold Coast Recreation & Sport Inc events and activities
- Notice of community meetings, stakeholder events and other community networks.

Would you like to receive information about our services and other related communication from us?

Please check the box to opt in ☐

You can opt out of receiving this material at any time by following the opt-out options in the relevant communication.

Signed _____ Date _____

Client/Parent/Guardian

Name _____

Please print name

Individual Recreation Plan – VISION

What is your 'Vision' for the future in planning for a good life and a secure future for your family member?

The 'future' can be tomorrow, next week, month or years from now. Creating a strong vision now, allows for plans to be made to make that vision a reality, and to develop ways to make sure the plan is continued into the future. Vision is a compass to keep us on track.

VISION STATEMENT (what we and our family members want in the future)	
ABILITIES & SUPPORT REQUIREMENTS	
RECREATION GOALS	
OTHER GOALS	

Client Profile

Client Details			
Family Name		**Given Name/s**	
Title		**Preferred Name/s**	
Sex	Male ☐ Female ☐	**Date of birth**	

Client Contact Details				
Usual Address				*(number & street)*
	(Suburb)			*(Postcode)*
Postal Address (if different to usual address)				*(number & street)*
	(Suburb)			*(Postcode)*
☐ *Please direct correspondence to the above address.*				
Telephone	**Home**		**Other**	
	Mobile		**Fax**	
	Business			
Email				

Emergency Contact Details				
Name			**Relationship to client**	
Telephone	**Home**		**Other**	
	Mobile		**Fax**	
	Business		**Email**	
Usual Address				*(number & street)*
	(Suburb)			*(Postcode)*
Postal Address (if different to usual address)				*(number & street)*
	(Suburb)			*(Postcode)*
☐ *Please direct correspondence to the above address.*				

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Reviewed and accurate on _____ Signed _____

Client Profile

Ethnicity			
Country of birth *(if not Australia)*		**Year of arrival**	
Indigenous status	Aboriginal but not Torres Strait Islander origin Torres Strait Islander but not Aboriginal origin Both Aboriginal and Torres Strait Islander origin Neither Aboriginal nor Torres Strait Islander origin Not stated		☐ ☐ ☐ ☐ ☐
Preferred language *(if not English)*		**Interpreter required**	Yes ☐ No ☐

Government Pensioner/Benefit Status		
Employed	Yes ☐ No ☐	Full-time ☐ Part-time ☐ Casual ☐
Government benefits	Disability Support Pension ☐ Veteran's Affairs Pension ☐ Aged pension ☐	Carer Payment (pension) ☐ Unemployment benefits ☐ Other ☐

Next of Kin (1)				
Name			**Relationship to client**	
Telephone	**Home**		**Other**	
	Mobile		**Fax**	
	Business		**Email**	
Usual Address	*(number & street)*			
	(Suburb)		*(Postcode)*	

Next of Kin (2)				
Name			**Relationship to client**	
Telephone	**Home**		**Other**	
	Mobile		**Fax**	
	Business		**Email**	
Usual Address	*(number & street)*			
	(Suburb)		*(Postcode)*	

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Client Profile

Disability Information			
Primary Disability group	Autism ☐	Developmental delay ☐	Intellectual ☐
	Physical ☐	Specific learning disability ☐	Sensory ☐
	Psychiatric ☐	Other (please specify) ☐	
Specific diagnosis	Down Syndrome ☐	Acquired brain injury ☐	ADD/ADHD ☐
	Cerebral palsy ☐	Asperger syndrome ☐	Paraplegia ☐
	Quadriplegia ☐	Hearing impairment ☐	Spina Bifida ☐
	Tetraplegia ☐	Visual Impairment ☐	Stroke ☐
Please provide any further relevant information about the nature of your disability.			

Abilities		
Strengths		
Interests		
Favourite activities		
Favourite places		
Ability to swim	Beach	Independent ☐ With assistance ☐ Not able ☐
	Pool	Independent ☐ With assistance ☐ Not able ☐

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Client Profile

Physical Movement and Mobility					
Walk without support	Home	Independent ☐	With assistance ☐	Not able ☐	
	Community	Independent ☐	With assistance ☐	Not able ☐	
Sit without support	Home	Independent ☐	With assistance ☐	Not able ☐	
	Community	Independent ☐	With assistance ☐	Not able ☐	
Please describe support required for movement and mobility.					

Transport			
Public transport	Independent ☐	With assistance ☐	Not able ☐
Comments			
Vehicle transfers	Independent ☐	With assistance ☐	Not able ☐
Comments			
Do you (the client) have a driver's license?		Yes ☐	No ☐
Do you (the client) require specialized transport?		Yes ☐	No ☐
Comments			

Communication			
Preferred method of communication	Speech ☐	Makaton ☐	Sign language ☐
	Writing ☐	Gestures ☐	Communication book ☐
Can you (the client) write?	Yes ☐ No ☐	Can you (the client) read?	Yes ☐ No ☐
Please describe reading/writing skills.			
Are you (the client) non-verbal?			Yes ☐ No ☐
Do you (the client) use communication aids or augmentative communication devices?			Yes ☐ No ☐
Please describe			
What is your (the client) YES/NO response?			
Can you (the client) indicate a choice between 2 options?			Yes ☐ No ☐

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Client Profile

Social Skills			
Working with adults/teachers/support staff	Excellent ☐	Good ☐	Poor ☐
Working with peers	Excellent ☐	Good ☐	Poor ☐
Working with the community	Excellent ☐	Good ☐	Poor ☐

Do you (the client) like to participate in group activities?	Yes ☐	No ☐
Do you (the client) make friends easily?	Yes ☐	No ☐
Do you (the client) prefer to spend time alone?	Yes ☐	No ☐

Behaviour		
Do you (the client) display challenging behaviours?	Yes ☐	No ☐
If yes, does the clients' behaviour pose a risk of harm to themselves or others?	Yes ☐	No ☐
If yes, is there a **Restrictive Practice** or **Behaviour Support Plan** in place?	Yes ☐	No ☐
Do you (the client) react to the following?	Crowds ☐ Noise ☐ Animals ☐	
Are there any activities that should be avoided?		
What safety issues need to be considered? (eg. Road, stranger danger, absconding)		

Office use only (to be completed at assessment interview)

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Independent Living Skills				
	Requires full assistance	**Requires supervised assistance**	**Requires prompting**	**Fully independent**
Toileting	☐	☐	☐	☐
Comments				
Dressing/Undressing	☐	☐	☐	☐
Comments				
Personal hygiene/grooming	☐	☐	☐	☐
Comments				
Bathing & showering	☐	☐	☐	☐
Comments				
Food & eating	☐	☐	☐	☐
Comments				
Shopping	☐	☐	☐	☐
Comments				
Money handling	☐	☐	☐	☐
Comments				
Budgeting	☐	☐	☐	☐
Comments				
Banking	☐	☐	☐	☐
Comments				
Household chores	☐	☐	☐	☐
Comments				
Telling time	☐	☐	☐	☐
Comments				

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Medical Profile

Client Details			
Family Name		**Given Name/s**	
Sex	Male ☐ Female ☐	**Date of birth**	

Client Medical Profile				
Doctor				
Address	*(number & street)*			
	(Suburb)		*(Postcode)*	
Telephone	**Business**			
	Mobile			
	Fax			
Specialist Doctor				
Preferred hospital				
Medicare number				
Private health insurance	Yes ☐ No ☐	Name of fund		

Medical Conditions			
Do you (the client) have any of the following?	Yes	No	Details
Heart condition			
Blood pressure problems			
Respiratory disease/asthma			
Renal disease			
Diabetes			
Hepatitis			
Epilepsy			***If yes,*** Epilepsy Profile must be completed.
Atlanto-Axial instability (people with Down Syndrome only)			
Other medical condition			

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Medical Profile

Allergies

Do you (the client) have any allergies?		Yes ☐ *(please describe below)*	No ☐
	REACTION	TREATMENT	
MEDICATION			
FOOD			
OTHER eg. Bee sting			
TAPES & DRESSINGS			

Dietary Requirements

Do you (the client) have special dietary requirements?	Yes ☐ *(please describe below)*	No ☐

Medical conditions

Do you (the client) have any other medical conditions?	Yes ☐ *(please describe below)*	No ☐

Medication

Do you (the client) take medication?	Yes ☐ *(please describe below)*	No ☐
If yes, is assistance required?	Yes ☐	No ☐

Medication name	Dose	Form (eg. Tablet, liquid)	Route (eg. Oral, injection)	Time taken

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Epilepsy Profile				
Have you (the client) ever had an Epileptic seizure?			Yes ☐	No ☐
Do you (the client) have a diagnosis of Epilepsy?			Yes ☐	No ☐
Type of Epilepsy	Tonic Clonic ☐	Absence ☐	Simple Partial ☐	Complex Partial ☐
	Other ☐			
	Details			
Is the epilepsy controlled?	Yes ☐	No ☐	Partially ☐	
How often do seizures occur?	Daily ☐	Weekly ☐	Monthly ☐	Less than monthly ☐
	Details			
How long do seizures last?	Less than 1 minute ☐	1 – 5 minutes ☐	More than 5 minutes ☐	
	Details			
Are there any triggers?	Yes ☐	No ☐	Partially ☐	
	Details			
What happens prior to a seizure?	No change ☐	Some behavior change ☐	Significant observable change ☐	
	Details			
What happens during a seizure?				

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Epilepsy Profile (continued)			
What happens after a seizure?	Fast recovery, limited ill effects ☐	Medium recovery time ☐	Long recovery time ☐
	Distressed ☐	Drowsy ☐	Disoriented ☐
	Details		

Gold Coast Recreation & Sport Inc. follows the following Epilepsy procedure.

1. Ensure safety of client and others
2. Cushion the head
3. Ensure airway remains open
4. Time the seizure
5. Offer support and reassurance
6. Allow the person to rest until they are fully recovered.

Where a seizure lasts longer than 5 minutes, GCRS follows the following procedure.

1. Continue to apply Epilepsy First Aid
2. Call an Ambulance
3. Call GCRS office, who will then contact Emergency contacts/Next of kin.

I (the client) am comfortable with the GCRS Epilepsy procedure	Yes ☐	No ☐

***If no**, please describe your (the clients') Epilepsy Management plan.*

Where a person has an individualised Epilepsy Management Plan, this will replace the GCRS procedure.

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Transport Profile

Gold Coast Recreation & Sport Inc is committed to providing support that is individualised, whilst providing opportunities for you (the client) to develop new skills and increase independence.

At all times your (the clients') health and safety is at the forefront of GCRS' service provision and GCRS is committed to ensuring that your safety is protected during transport to and from your home.

If you (the client) receive transport assistance please select an appropriate level of support you wish to be provided, in the development of your independence and personal safety.

Client Name	

☐ **1** A family member/carer should always be present upon delivery to the home.
Support **is** required to enter and exit a vehicle.
Support **is** required to enter the home.
Physical and verbal handover may be provided.

☐ **2** A family member/carer should always be present upon delivery to the home.
Minimal support is required to enter and exit a vehicle.
Support may be required to exit vehicle but may not be required to accompany an individual to the door.
GCRS employees shall observe client to enter their home, and will not drive away until the client is inside the home/property.

☐ **3** The client is allowed to be in the home **without supervision**.
The client may carry, or be responsible for house keys etc.
The client may have the ability to unlock gates and doors, and enter the home independently. GCRS employees may provide support to unlock gates and doors.
GCRS employees shall observe client to enter their home, and will not drive away until the client is inside the home/property.

Please provide any other details that may assist us with your transport.
Eg. Security gate code, difficult driveway, independent with seat belt.

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date Client / Parent / Guardian