For Office Use		
		Initial
Date Recieved:		
Date IC Booked:		
Date of IC:		

RAINBOW HUB

ADULT SERVICES APPLICATION FORM

Name: .....

Date of Birth: .....

Please tick the service you are interested in:

Conductive Education	
Physiotherapy	

PERSONAL INFORMATION

ABOUT YOU	
First Name Surname	Date of Birth
Gender	Age
Address Postcode	Day telephone number Evening telephone number E-mail

ABOUT YOUR MAIN CARERS (if applicable)	
Primary carers name Contact Telephone numbers (mobile or work) E-mail Address	Secondary carers name Contact Telephone numbers (mobile or work) E-mail Address

EMERGENCY CONTACTS IN ADDITION TO MAIN CARER	
Emergency Contact person #1	Emergency Contact person #2
Relationship to you	Relationship to you
Home telephone number	Home telephone number
Mobile number	Mobile number

MEDICAL INFORMATION

Please use an additional sheet if necessary

ABOUT YOUR CONDITION AND YOUR HEALTH NOW

Have you got a diagnosed condition? (please circle answer) YES/NO

If Yes, please specify (nb If you have Cerebral Palsy please specify i.e. quadriplegia, diplegia, hemiplegia, ataxia, athetosis)

If you have an acquired condition, please state how and when the condition presented itself.

Is there any information about your disability or development that you think may be important for us to know please state below (e.g. contractures, spasms, deformities, dislocations, injuries etc..)

Do you have or have you ever had the following (please circle answer)

Heart Problems	YES/NO	If Yes, please give details
Blood Pressure	YES/NO	If Yes, please give details
Breathing Problems	YES/NO	If Yes, please give details
Diabetes	YES/NO	If Yes, please give details
Arthritis	YES/NO	If Yes, please give details
Osteoporosis	YES/NO	If Yes, please give details
Epilepsy	YES/NO	If Yes, please give details

Have you had any orthopaedic surgery? If yes please give details.

Do you have any difficulties in the following areas: If yes please give details

Hearing difficulties:

Visual difficulties:

Other sensory difficulties:

Are you on any other medication? If yes please give details

Do you have any allergies or dietary requirements? If yes please give details

continued...

Who do you live with? Or do you live alone?

Do you require support from others (i.e. parents or carers) on a daily basis? if so, what type of support do you have?

Do you require support from others when making decisions etc: YES/NO. If yes, who usually helps you in this way?

DEVELOPMENT

YOUR ABILITIES

Please indicate if you are able to do any of the following and if so, how do you do them. Please give details of any assistive devices you use e.g. orthotics, turntable, transfer board, hoist etc....

Head Control (i.e. able to lift head up):

Rolling:

Crawling:

Sitting (on floor or on chair):

Standing:

Stepping:

Moving from sitting to standing:

Walking:

Transfers (i.e. chair to bed, bed to chair etc):

Use of hands (i.e. grasping, releasing, transferring objects):

SELF CARE SKILLS

Please give details of your current level of abilities in the following areas:

Eating/drinking (If your child has any specific difficulties with eating or drinking (e.g. tube fed, aspiration etc... please specify)

Dressing/undressing:

Toileting needs:

COMMUNICATION

Please describe how you indicate your needs (e.g. smiling, talking etc...)

Give details of any assistive device you use to communicate (e.g. signing, symbols, computer etc...)

Do you have any difficulties in understanding spoken language? If yes please specify

GENERAL INFORMATION

ANY EXTRA INFORMATION
Do you have any religious and/or cultural beliefs that you would like us to be aware of?
What activities do you particularly enjoy? Or dislike?
Please give details of any other activities, interventions or therapies that you have attended (e.g. swimming, horse riding, physiotherapy, previous conductive education etc.)
Do you use any assistive devices (e.g. standing frame, splints, boots etc...)? If yes please give details
How did you find out about our services?
Do you have any pre-existing knowledge or experience Physiotherapy or Conductive Education? If yes please give details
What do you hope you will achieve through our services?
Any other comments you would like to make about yourself

THANK YOU

One of our team will contact you shortly with an assessment date.

The information I have written on this form is true and accurate to the best of my knowledge and I understand that this form is not an acceptance of a place but is used as part of an assessment tool to assess whether any of the services offered by TLRH are suitable for me.

SIGN .....

PRINT .....

DATE .....

If signed on behalf of an adult please state your relationship to them below:

.....

RAINBOW HUB

FOLLOW YOUR DREAMS, WHATEVER YOUR ABILITY