AHA Client Details Form

Client Details	
Full Names & Surname:	Date of Birth:
Identified Gender:	Stage of Development:
NDIS nr:	Managed: Agency/Plan/Self Plan Manager:
Pension/DVA Nr & Expiry	
Medicare Nr & Expiry	
Private Health Nr & Expiry	
Home Phone:	Mobile Phone:
Work Phone:	Email Address:
Cultural Background:	Country of Birth:
Religion	Practicing? ○ Yes ○ No
Preferred Language:	Interpreter Required? ○ Yes ○ No
Address:	

For Equine Program Purposes			
Height:	Weight:	Shoe size:	T-shirt size: S/M/L/XL

- **Wear tights for riding**
- **Wear riding boots**
- **Wear riding helmet for safety**

Guardian Details (if applicable)	
Name:	Date of Birth:
Home Phone:	Mobile Phone:
Work Phone:	Email Address:
Address:	

Participant Vital Data – Emergency purposes	
Provider	**Contact details**
General Practitioner (Name & Address)	Tel nr: Email: Emergency A/H nr:
Paediatrician	Tel nr: Email:
Psychologist	Tel nr: Email:
Occupational Therapist	Tel nr: Email:
Speech Therapist	Tel nr: Email:
Support coordinator	Tel nr: E-mail:
Plan Manager	Tel nr: Email:
Other Emergency Contact	Tel nr: Email:
Ambulance Membership Nr & Expiry	
Insurance Fund Nr & Level of Cover	
Funeral Director	
○ Burial ○ Cremation ○ Other	
Other Health Practitioners/Specialists (Provide Type & Name)	
1	
2	
3	
Other Allied Health Practitioners (Provide Type, Name, Contact Details)	
1	
2	
3	

Emergency Contact Details	
Person 1	**Person 2**
Name	Name
Phone (W):	Phone (W):
Phone (A/H):	Phone (A/H):
Phone (M):	Phone (M):
Email:	Email:
Address:	Address:

Risk Factors / Alert Issues

_____

_____

Medical History

_____

_____

_____

Presenting Issues / Problems / Behaviours of concern

_____

_____

_____

Other Relevant Current and Historical Information

_____

_____

_____

Presenting Disabilities

_____

_____

Power of Attorney	
Person 1	**Person 2**
○ Power of Attorney (financial) ○ Enduring Power of Attorney (financial & personal) ○ Enduring Power of Attorney (medical treatment) ○ Supportive Attorney ○ Guardian	○ Power of Attorney (financial) ○ Enduring Power of Attorney (financial & personal) ○ Enduring Power of Attorney (medical treatment) ○ Supportive Attorney ○ Guardian
Name:	Name:
Phone (W):	Phone (W):
Phone (A/H):	Phone (A/H):
Phone (M):	Phone (M):
Email:	Email:
Address:	Address:
Guardianship ○ Yes ○ No *(If yes, please attach supporting documents and attach a separate sheet if more than one guardian.)*	
Please select: ○ Limited Order ○ Plenary Order ○ Enduring (pre-1st September 2015)	
Organisation:	
Email:	Phone (A/H):
Phone (W):	Phone (M):
Surname:	Given names:
Address:	Postcode:
Administrator ○ Yes ○ No *(If yes, please attach supporting documents and attach a separate sheet if more than one guardian.)*	
Please select: ○ Limited Order ○ Plenary Order	
Organisation:	
Email:	Phone (A/H):
Phone (W):	Phone (M):
Surname:	Given names:
Address:	Postcode:
Is there an **Advance Care Plan/Care Directive** in place? ○ Yes ○ No Is there a copy on file? ○ Yes ○ No	

Executor of Will	
Email:	Phone (A/H):
Phone (W):	Phone (M):
Surname:	Given names:
Address:	Postcode:

Client / Guardian Declaration

I consent to my information being provided to Angel House Australia for the purposes of referral, service delivery and inclusion in de-identified data reporting.

Full Name _____ Date _____

Signature of Client/Guardian _____

Designation: _____

SEPARATION - OFFICE USE ONLY Date of ceasing services:
○ Death ○ Entered Residential Care ○ Other:

Full Name _____ Date _____

Signature _____

Designation: _____