



SERVICE USER APPLICATION

A. Personal Details

Service User Application

NAME: _____ D.O.B _____

ADDRESS: _____ PHONE: _____

SEX: MALE [] FEMALE []

COUNTRY OF BIRTH: _____

LANGUAGE SPOKEN AT HOME: _____

INTERPRETER REQUIRED: YES [] NO []

LANGUAGE: _____

CULTURALLY / LINGUISTICALLY DIVERSE BACKGROUND
YES [] NO []

DETAILS : PARENT/GUARDIANS: (names)

ADDRESS: _____

REFERRED BY: _____

SERVICE TYPE APPLYING FOR:



B. Medical / Health Information

DISABILITY: (Primary)

(Secondary Support Requirements)

Physical	Yes	[	]	No	[]
Visual Impairment	Yes	[	]	No	[]
Intellectual Disability	Yes	[	]	No	[]
Autism	Yes	[	]	No	[]
Learning Difficulties	Yes	[	]	No	[]
Hearing Impairment	Yes	[	]	No	[]
Aquired Brain Injury	Yes	[	]	No	[]
Epilepsy	Yes	[	]	No	[]
Psychiatric	Yes	[	]	No	[]
Diabetes	Yes	[	]	No	[]
Asthma	Yes	[	]	No	[]
Speech Impairment	Yes	[	]	No	[]
Gastric Tube	Yes	[	]	No	[]

Current Health Support Requirements:

ALLERGIES: _____

PHYSICAL REACTION TO ALLERGY : _____

HISTORY OF SEIZURES: Type and frequency _____

TREATMENT OF SEIZURES: _____



Name: _____ **Please note behaviour plan will be required

C. Psychological / Behavioural Issues

TYPE OF BEHAVIOUR	YES	NO	NOTES
Aggression	[]	[]	_____ _____
Inappropriate Sexual Behaviour	[]	[]	_____ _____
Wandering off with risk to safety	[]	[]	_____ _____
Self Injurious Behaviour	[]	[]	_____ _____
Property Damage	[]	[]	_____ _____
Obsessive Behaviour	[]	[]	_____ _____
Screaming / Spitting	[]	[]	_____ _____
Other	[]	[]	_____ _____



D. Support Requirement

Service User Application

Communication Ability

Physical Assistance Required Yes [] No []

Wheelchair Yes [] No []

Crutches Yes [] No []

Walking Frame Yes [] No []

Hoist required Yes [] No []

Personal Care assistance Yes [] No []

Feeding Yes [] No []

Tube Feeding Yes [] No []

Swallowing Difficulties Yes [] No []

Toileting Yes [] No []

Dressing Yes [] No []

Weight Bearing Yes [] No []

Other
