Group Program - Information Form

17 Robe Street, PO Box 3058, Port Adelaide, SA, 5015
Ph.: (08) 7228 0248
Email: hello@bloomwellbeing.com.au
Web: www.bloomwellbeing.com.au

Client Details

Name:			
Gender:	☐ Male ☐ Female ☐ Other _____	**Date of Birth:**	
Address:			
Suburb:		**Postcode:**	
Parent/Guardian Name/s:			
Home Phone:		**Mobile:**	
Email Address:			
If you do not wish to be subscribed to our mailing list please check this box: ☐			

FUNDING DETAILS

NDIS approved?	☐ **Yes** ☐ **No**	**NDIS Number:**	
Is Your Child's Plan: (Please Tick One)	☐ **Self-Managed** ☐ **Plan Managed (please give details of Plan Manager/Support Co-Ordinator):** **Plan Manager:** **Contact Name:** **Email Address for Invoices:** ***Unfortunately we are not able to accept Agency Managed participants***		

GP / Medical Practitioner Details

Name of Doctor:			
Name of Clinic:			
Address:			
Suburb:		**Postcode:**	
Phone:		**Fax:**	
Email Address:			

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Other Health Practitioner Details

Name:			
Profession:			
Name of Clinic:			
Address:			
Suburb:		**Postcode:**	
Phone:		**Fax:**	
Email Address:			

Name:			
Profession:			
Name of Clinic:			
Address:			
Suburb:		**Postcode:**	
Phone:		**Fax:**	
Email Address:			

What We'd Love to Know About Your Child

Tell me a little bit about your child – What are their best qualities? What is they like as an individual? What makes them special?	
What sort of things does your child enjoy, or love to do – eg. craft, sports, interests, favourite book or TV characters.	
What goals do you and your child have for attending Bloom Wellbeing?	

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Medical History & Background…

Please list any diagnosed conditions your child has? Include date of diagnosis.	
Please list any relevant family medical history.	
Please list any medications your child is currently taking.	
Please list any past or current therapy your child has had	
Any other relevant information about this child's medical history?	

Social & Home

Who lives in the home with your child? Parents, /siblings/other	
Does your child attend school, which grade?	
How would you describe your child's social skills? How well do they build relationships with other children/adults	

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Please use the following space to provide any further information you think is important for the program facilitator to know:

Signed: _____ Date: _____
(Parent/Guardian)

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Authority To Release/Obtain Information

I, _____ (*Name*), Parent/Guardian of

_____ (*Name*), _____ (*DOB*)

of _____ (*Address*)

provide consent for staff of Bloom Wellbeing, to release and obtain medical information (written and verbal) relevant to my child's Occupational Therapy program, to and from the following: (please list relevant agencies/individuals)

1. National Disability Insurance Authority
2. _____
3. _____
4. _____

I understand that the information obtained or released by the above listed parties will be of a factual nature concerning matters relevant to my child's Occupational Therapy program.

I consent to my child's personal information being released by fax or email when general post will not allow effective and efficient communication.

☐ Yes

☐ No

I understand:

- That I can change or cancel this authority at any time
- This authority may be used until the completion of my child's Occupational Therapy program, or until I withdraw my authority (whichever comes first)
- That internet and facsimiles can be insecure means of communication. I am aware that a risk exists that my data may be accessed and read during transmission. However, for all emails sent over the internet and facsimiles transmitted via the phone system, Sarah Hausler and Bloom Wellbeing staff will strive to ensure the confidentiality of my personal information as far as possible and in compliance with privacy laws.

Signed: _____ Date: _____