

Kogarah Neighbour Aid Program



CLIENT RECORDS UPDATE

Title	Full Name	Prefers to be called
Address		Telephone Number
		()
	State	Postcode
Country of Birth	Ethnicity	Date of Birth
		/ / 19
Language Spoken		Current Age
Religion		Are you Aboriginal or Torres Strait Islander?
		YES / NO <small>please circle</small>

Please list any assistance you receive on a regular basis from a carer, friend, social club or church group etc.

Please tick the types of services you would like to receive from Kogarah Neighbour Aid?

Outings & Social Groups <input type="checkbox"/>	Knot just Knitting Group <input type="checkbox"/>	Creative Art Group <input type="checkbox"/>
Shopping Assistance <input type="checkbox"/>	Men's Club <input type="checkbox"/>	Gentle Walking Group <input type="checkbox"/>
Friendly Phone Chats <input type="checkbox"/>	Companion Home Visits <input type="checkbox"/>	Gentle Exercise <input type="checkbox"/>

Please list other ideas:

EMERGENCY CONTACT & MEDICAL INFORMATION

First Emergency Contact	Telephone Number	Mobile/Work Number
Name:	()	
Address:	Relationship to you	
	Son <input type="checkbox"/> Daughter <input type="checkbox"/> Friend <input type="checkbox"/> Neighbour <input type="checkbox"/> Other <input type="checkbox"/>	
	Postcode	

Second Emergency Contact	Telephone Number	Mobile/Work Number
Name:	()	
Address:	Relationship to you	
	Son <input type="checkbox"/> Daughter <input type="checkbox"/> Friend <input type="checkbox"/> Neighbour <input type="checkbox"/> Other <input type="checkbox"/>	
	Postcode	

GP Doctor's Name	Medical Centre & Suburb	Telephone Number
		()
Do you own your Home? YES / NO	Do you live: <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse or Partner <input type="checkbox"/> With Relative or Other	
Are you receiving a Pension? YES / NO	What Type of Pension? <input type="checkbox"/> Aged <input type="checkbox"/> Disability <input type="checkbox"/> Vet Affairs	
Pension Number	Do you have Private Health Insurance?	What Health Fund?
	YES / NO	
Membership Number	Do you have Ambulance Cover?	

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CLIENT HEALTH DETAILS

Please list any health problems e.g. hearing & sight, allergies, incontinence, previous stroke history, heart condition etc.

Please tick all of the following tasks that you can do on a daily basis independently.

Grocery Shopping <input type="checkbox"/>	House Work <input type="checkbox"/>	Use a Telephone <input type="checkbox"/>
Bank / Pay Bills etc <input type="checkbox"/>	Minor Home Maintenance <input type="checkbox"/>	Shower yourself <input type="checkbox"/>
Prepare Meals <input type="checkbox"/>	Access Public Transport <input type="checkbox"/>	Dress yourself <input type="checkbox"/>

Do you use an aid for mobility? *please circle*

CANE	WALKING FRAME	NO
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What transport do you use to access the community? *please circle*

CAR	TRAIN	BUS	TAXI	Other: _____
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Do you have a carer?

YES	NO
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If you have a Carer, please provide their contact details.

Name: _____	Phone: () _____
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Address: _____

Does your carer live with you?

YES	NO
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	Postcode
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What other services are you currently receiving: (ie. shopping, meal deliveries, homecare or personal assistance etc.)

Please list any services you feel you need in addition to what you are already receiving.

I as a client of Kogarah Community Services believe that all information that I have provided on this Client Record Update form to be correct & current as of the date that I completed & signed this declaration. I consent to this information being used to update my personal client records within Kogarah Community Services ~ Neighbour Aid Program.

As a client & member of Kogarah Community Services Inc., I give permission to Kogarah Community Services Inc. representatives to contact my emergency contact and/or seek Medical attention should I become unwell whilst attending an Outing or Activity. I release Kogarah Community Services Inc. and individuals from liability in case of accident during activities related to Kogarah Community Services Inc., as long as normal safety procedures have been taken. I will notify Kogarah Community Services Inc. before any event if my health issues or contact have changed since the last event. I understand that photographic & video material taken during KCS activities is for promotional use & I will advise KCS in writing should I not want my photo taken.

Signature

Date

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In the event of an emergency whilst I am involved in outings and activities with Kogarah Community Services, I authorise all medical and surgical treatment, (x-ray, laboratory, anesthesia and other medical and/or paramedics) for myself and waive my right to informed consent of treatment. **This waiver applies only in the event that neither emergency contact/advocate can be reached in the case of an emergency.**

Signature

Date

	/ /	
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Thank you for taking the time to complete this record of your personal details. Please return it to: Kogarah Neighbour Aid Coordinator, PO Box 466 South Hurstville NSW 2221, *within 7 days of receiving it.*

Please ensure that both areas for your Signature (above) have been signed before returning the form.