VICTORIAN CONTINENCE RESOURCE CENTRE

Service/Appointment Request

Continence Foundation of Australia
NEW SOUTH WALES

Date Completed:	**Completed By:**
CLIENT NAME:	
NDIS PLAN NUMBER:	
CLIENT ADDRESS:	
Is this Supported Disability Accommodation?	**SRS / SDA / OTHER**
DATE OF BIRTH:	GENDER:
CLIENT PHONE:	EMAIL:
REFERRER NAME :	
RELATIONSHIP: **e.g. Support Coordinator / House Support / Next of Kin / POA/ Parent**	
ORGANISATION:	
MOBILE:	OFFICE PHONE:
EMAIL:	

Continence Service Requested:	☐ Nurse Continence Specialist	☐ Pelvic Floor Physiotherapy
☐ CHSP	☐ Paediatric	☐ NDIS
Reasons for Appointment:	☐Bladder	☐Bowels
☐NDIS Reporting	☐Review/Follow Up	☐Bed Wetting
☐Condom Drainage/Training	☐Products Recommendation	☐Toilet Training (Need 10+ hours)
☐Nurse Assisted Training (Check funding)		☐Other
Appointment Location:	☐ Telehealth/Phone	☐ In Clinic
☐ External (N.B. External appointments in exceptional circumstances only – approval required)		
Disability Details:	☐Physical	☐Neurological
☐Intell/Dev	☐ASD	☐Mental Health
☐Cerebral Palsy	☐Non-verbal	☐Prostate
☐Spina Bifida	☐Down Syndrome	☐ Other
Further Medical Information:		
Payment Details:	☐ NDIS Portal Claim	☐ PayPal/Cash (**Self-Managed Plans**)
☐ CHSP	☐ **INVOICE to a Financial Plan Manager**	
Plan Manager Invoice EMAIL & Phone :		

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Risk/Safety/Appointment Screen			
Name of person providing safety information:			
Relationship to Client:			
Signature:		**Date:**	
Will anyone else be present during the appointment?		☐Yes	☐No
Please list ALL attendees:			
Are there any Functional or mobility issues?		☐Yes	☐No
Functional Aids:	☐Walking Stick	☐Frame	☐Wheelchair
☐Mobility Scooter	☐ Other		
Communication: (hearing, speaking, language, understanding)			
Are there any communication difficulties?		☐Yes	☐No
If Yes, Please provide details			
Is an Interpreter Required?		☐Yes	☐No
What Language Interpreter?			
Is there any history of behaviours of concern?		☐Yes	☐No
Please specify any that apply:	☐ Aggressive	☐ Challenging /Confrontational	
	☐ Violent	☐ Other	
If yes indicated to any of the above please provide recommended procedure for approaching the client. Please note, our staff are not able to implement any restrictive practices. ***Please provide a separate sheet if necessary***			
Does the client have a Restrictive Practices Plan?		☐Yes	☐No
If yes, please provide a copy of the plan			
Does the consumer's cognitive or mental status affect their activities of daily life? (e.g. memory loss, confusion, aggression, unpredictable behaviour)		☐Yes	☐No
Are you aware of any other issues that might put our staff at risk?		☐Yes	☐No

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COMPLETE IF HOME VISIT REQUIRED (N.B. Home visits only arranged in exceptional circumstances)		
Reason for Home Visit		
☐ New South Wales CHSP client	☐ Aged Care Facility	☐ SRS/DHHS Accommodation
☐ Significant mobility difficulties	☐ Medically / Permanently confined to bed/home	
☐ Other Extenuating circumstances (Explain fully)		
Please indicate the premises type:	☐ Aged Care Facility	☐ SRS/DHHS Accommodation
☐ Private House/ Unit/ Apartment	☐ Medical Facility / Psychiatric Facility /Prison	
☐Other		
Is the address easy to find and clearly numbered?	☐Yes	☐No
Is there any difficulty to access to the dwelling?	☐Yes	☐No
please tick all applicable:	☐ Locked Gate / Buzzer Entry	☐ Steep/ Narrow/ Stairs
	☐ Entry via other than main entrance	☐ Dogs
	☐ Unkempt premises	☐ Squalid /Hoarder Conditions
Is there safe unrestricted parking in the immediate area?	☐Yes	☐No
If no, please advise where to safely park:		
Is there mobile phone reception in the area?	☐Yes	☐No
Are there any dangerous weapons or firearms kept on the premises?	☐Yes	☐No
If yes, are they securely locked away?	☐Yes	☐No
If 'No" home visit NOT advised		
Are there any pets in the house?	☐Yes	☐No
If yes, please contain securely in another room or outside during clinician visit		
Does anyone smoke in the house?	☐Yes	☐No
	If yes, please request NO SMOKING during clinician visit	
Does anyone in the house have a current history of violence and/or drug abuse?	☐Yes	☐No
If yes, please request they not be present during the clinician visit or offer an alternative type of appointment		
Does anyone in the house currently have a suspected or confirmed infectious illness?	☐Yes	☐No
If yes, please list all conditions (e.g. Measles, Flu, Gastro, COVID19)		
***** If yes, please be advised that clinician visit may need to be rescheduled *****		

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OFFICE USE ONLY:

☐Telehealth only ☐Clinic Visit Only ☐Visit Alone ☐2 Person Visit

Clinician Visit by: _____ Date: _____

Any contradictions to information provided? ☐Yes ☐No
If yes, please list:

_____

Any hazards identified? ☐Yes ☐No
If yes, please list:

_____

Can home visit address be found on Maps/Satellite Navigation? ☐Yes ☐No
Incident Report / Additional Notes:

_____