EXPRESSION OF INTEREST FORM

This is an Expression of Interest for applying for accommodation at Ferguson Lodge for permanent, respite, transitional and short stay. Please note the following:

1. **All sections must be completed for an Expression of Interest to be processed**
2. **Email completed Expression of Interest to: accommodation@paraquad.org.au**

Date of Enquiry: ……/……/……

Please tick the accommodation you are applying for:

Full Care Room within Ferguson Lodge main building
☐ permanent
☐ respite (discharge destination required)

Villa two bedroom, fully accessible, care package, discharge destination required
☐ transitional
☐ short stay

Personal Details

Full Name:……..

Home Address:…….....

State: Postcode…….

Date of Birth:……/……/…… Gender:

Phone Number: (H)……(M)…….(Other)……..

Email:……

Present Address, if different to above (e.g. Hospital, Spinal Unit, Nursing Home)

……

State: Postcode……..

Next of Kin:……..... Relationship:……..

Contact Details:……

……...

Cultural Background

Is your first language English?

If No please state ……..…….....

Do you require an Interpreter

If Yes – which language?……

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Are you: Aboriginal Torres Strait Islander Neither

Is there anything we should be aware of so that we can ensure that we deliver culturally appropriate services to you:

……..

……

Period of accommodation sought: Please tick and provide dates

Permanent: from ……../……./…….
Respite:from ……../……./…… until ……./……./…….
Transitional: from ……../……./…… until ……./……./…….
Short Stay: from ……../……./…… until ……./……./…….

Discharge Destination – must be fully wheelchair accessible OR meet your mobility needs

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If you are seeking Transitional Accommodation, please outline your plans and any support you require to assist with gaining accommodation following discharge.

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Have you applied for housing through social housing?

If Yes, please provide T-number assigned to you. ……

Any Other Reason for Admission Request?

……

……

Referred by

Name:……

Address:……

Phone:……

Email:……

Lesion Level:…….Complete Incomplete

Cause of Injury:…….Date of Injury: …../…../…..

Are you a permanent resident of Australia?

Are you a Pensioner? if so state type of Pension DSP / Age

Are you receiving Sickness Benefits?

Are you eligible for a Compensation Claim?

Are you in employment? Full time / Part-time

Are you seeking employment? Full time / Part-time

Are you a member of ParaQuad?

Current source of Funding Provider and Income (Please tick the right option and fill in the details)

- ☐ **NDIS Participant**: No. of hours currently funded…….

  Does your NDIS Package cover respite:

  NDIS Participant Number:……..

  Does your NDIS Package provide support for other evens that you wish to continue whilst on respite?

  If yes - please describe,

  ……

  ……

- ☐ **Care & Support Provider**:
  Name of organization:

  ……..

  Name of provider:……

  No. of hours currently funded.....

- ☐ **Compensable/Insurer**:
  Name of organization:

  ……

  Name of Service Provider:

  ……

  No. of hours currently funded.....

- **Self Funded:**
  Name of organization:

  ……

  Name of Service Provider:

  ……

  No. of hours currently funded.....

- **Other:**
  Name of organization:

  ……

  Name of Service Provider:

  ……

  No. of hours currently funded.....

Medical History *Please attach any referrals, discharge summaries, Doctors letters or other relevant information)*

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……

Do you have any known Infections and / or Infection Risk? If yes please provide details of the infection and current treatment/s

……

……

Do you suffer from Autonomic Dysreflexia? If yes treatment used:

……

Do you have any Pressure Areas? If yes, please describe:

Site:……

Grade:……

Current Treatment:……

Do you have any Respiratory Conditions?

Overnight Sleep Apnoea? If yes, do you use: CPAP BIPAP

Tracheostomy/ Ventilated?

Recurrent Chest Infections?

Asthma?

Other:……

Have you had an assessment by a Speech Pathologist

If yes please provide a copy of the assessment.

Do you have a modified diet and/or mealtime assistance requirements when eating or drinking?

If yes please provide a copy of all relevant documents for your modified diet and mealtime requirements.

Are you Diabetic? If yes, please tick how your diabetes is managed below:

Diet controlled Medication Insulin

Do You Smoke Tobacco?

If Yes - How many cigarettes per day _____

Do You Drink Alcohol?

If Yes – How many drinks per day_____ / per week_____

Medications:

Please list all medications currently used – add additional pages if required.

MEDICATION *Please include Prescribed and Over The Counter Medication*	**How often do you take this medication**	**How long have you used this medication**
OTHER SUBSTANCES USED Illicit & other non prescribed substances	**Frequency Of Use**	**How long have you used this substance**

Other Medical Conditions which may impact your care needs?

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……

……

General Practitioner Contact Details

Name:……

Address:……

Phone: ……..

Spinal Specialist

Name:……

Hospital:……

Date last reviewed: …../……/…….

Phone: ……..

Signature of Applicant

……

Guardian (and / or co-signatory if required)

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