Guest Personal Profile

By gathering this information we are able to better assess your support needs which will enable a safe and enjoyable Holiday. Please fill out as accurately as possible to allow for activity plans and support that best meet your needs. All information provided in this form will be kept confidential.

[This is a word protected form. Complete by clicking in the empty boxes. Use tab to move to the next box. There are restrictions to length of text accepted in each box.]

GUEST DETAILS					
Guest Name:				D.O.B.	
Home Address:					
		State:		P/code:	
Email:					
Phone:		Mobile:			
Medicare No:		Valid to:			
Hobbies/Interests:					

EMERGENCY CONTACTS			
Contact 1		Contact 2	
Name:		Name:	
Relationship to guest:		Relationship to guest:	
Phone:		Phone:	
Mobile/Work:		Mobile/Work:	

MEDICAL DETAILS			
G.P. Name		Phone:	
Address:			
Primary Disability/Condition			
Secondary Disability/Condition			
Any other relevant information about your disability			

Freedom 4U SUPPORTED HOLIDAYS

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Allergies:

Medical or Personal Needs/Issues (e.g. epilepsy, phobias, behaviours, toileting needs)

Are you or others at risk with the above needs/ issues? YES ☐ NO ☐

If YES, what are the strategies we need to use to minimise these risks, or, PLEASE attach relevant management plan/s.

COMMUNICATION

Method used:

Verbal Speech ☐ Simple sentence speech ☐ With Gestures ☐ Facial Expressions ☐

Other:

Able to:

Read YES ☐ NO ☐

Write YES ☐ NO ☐

Tell the Time YES ☐ NO ☐

Follow Basic Directions YES ☐ NO ☐

Understand/follow two-part directions YES ☐ NO ☐

DIET AND NUTRITION

List any special dietary requirements, (e.g. special diet, soft foods, cut up etc.)

Food/drinks you dislike or to be avoided:

***** *Some of our social activities may be at a venue where there is alcohol.* ******

Do you drink alcohol? YES ☐ NO ☐ **List details:**

EQUIPMENT NEEDS

List any equipment required
(e.g. shower chair, bedrails, mackintosh, Kylie (mattress protector) eating utensils, transport needs.)

Can you walk up and down stairs? YES ☐ NO ☐

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MEDICATION

**** all prescribed medications MUST be in a blister/webster pack with photo ID attached. ****

Please indicate when taken: Before meal ☐ With meal ☐ After meal ☐

Is assistance required? (e.g. prompts, pushing out tablets, supervising)

Name of Medication	Reason Prescribed	Dose	Time Taken	Side Effects	Comments

PRN MEDICATION

NO ☐ YES ☐	**If Yes Name Medication:**
Reason Prescribed:	
When taken & frequency:	
Date last taken:	
Comments:	

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PERSONAL CARE

Please indicate **F** = fully assist **A** = assist **P** = prompt **S** = supervise or **I** = independent

Is assistance required with....?	Please check relevant box					Comments
	F	A	P	S	I	
Showering/ Bathing	☐	☐	☐	☐	☐	
Shaving	☐	☐	☐	☐	☐	
Cleaning Teeth	☐	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	☐	
Drying	☐	☐	☐	☐	☐	
Menstrual Hygiene	☐	☐	☐	☐	☐	
Using Toilet	☐	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	☐	
Drinking	☐	☐	☐	☐	☐	
Changing or choosing appropriate clothes	☐	☐	☐	☐	☐	
Regulate Water Temp	☐	☐	☐	☐	☐	

TYPICAL 24 HOUR DAY

Please describe a typical 24 hour day: include meal times and when medication is taken, shower times etc.

AM	Time awake:	PM	Time to bed:
			Do you wake during the night? NO ☐ YES ☐