



<p><b>Brisbane Office</b> PO Box 1512, Coorparoo DC Q 4151 967 Stanley St, East Brisbane, 4169 Ph: (07) 3891 5466 Fax: (07) 3891 5706 www.lifestream.org.au</p>	<p><b>Mackay Office</b> PO Box 1972, Mackay Q 4740 Cnr Juliet St &amp; Bridge Rd, Mackay 4740 Ph: (07) 4957 4612 Fax: (07) 4951 4103 www.lifestream.org.au</p>	<p><b>Rockhampton Office</b> PO Box 1263, Rockhampton Q 4700 74 Victoria Parade, Rockhampton 4700 Ph: (07) 4931 3057 Fax: (07) 4931 3059 www.lifestream.org.au</p>
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## NEW MEMBER APPLICATION FORM

- Please write clearly in **BLOCK LETTERS** to ensure we record accurate information.
- The information you provide allows us to accurately assess your needs.
- All information will be treated confidentially.
- This form needs to be returned before you can undertake any **LIFE STREAM** activities.
- Please contact us if you:
  - Have any questions about filling out this form.
  - Require this form in an alternative format.
  - Require a **LIFE STREAM** staff member to assist you to complete this form.
- If any of this information changes, please provide the new information to the **LIFE STREAM** office immediately.

### MEMBERS PERSONAL DETAILS

First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Preferred First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male  Female

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Suburb/Town: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Phone Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Best person to contact regarding Programs & Confirmations:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Do you have an Adult Guardian?**

Yes  No

If yes, Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb/Town: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Phone Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

**Please provide the following information if living in supported accommodation:**

Name of Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb/Town: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact 1:**

Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Phone Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact 2:**

Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Phone Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Please give a brief outline of your disability:

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION**

Do you have a Statutory Health Attorney?      Yes       No

If yes, Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb/Town: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone Home: \_\_\_\_\_ Phone Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Local Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Provide a brief medical history noting any major illness or surgery:

\_\_\_\_\_  
\_\_\_\_\_

Are you affected by any of the following? **(If yes, please provide details)**

**Hearing Impairment**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Visual Impairment**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Allergies**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Asthma**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Heart Condition**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Diabetes**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Sun Sensitivity**      Yes       No

Details: \_\_\_\_\_  
\_\_\_\_\_

**Mobility Restrictions**

Yes  No

Details: \_\_\_\_\_

**Seizures**

Yes  No

What type of Seizures do you experience?	
How often do you have seizures?	
What warning signs can our staff/ volunteers look out for?	
Specific Triggers	
How do you want Life Stream to manage your seizure?	
What do you do after a seizure?	
Is there any other information you would like to tell Life Stream in relation to managing your seizures?	

***Please note, unless otherwise stated, Life Stream will call an ambulance if a member has a seizure that lasts more than two minutes, OR, the seizure occurs in water.***

## Medication

We understand that often medications change over the course of time and can sometimes change the day before a program. However, please answer the following questions to give us an idea of the attention to medication that you will require.

Do you take medication? Yes  No

Are you able to self-administer your medication? Yes  No

If not able to self-administer medication, do you take medication at:

Breakfast Yes  No

Morning Yes  No

Lunch Yes  No

Afternoon Yes  No

Dinner Yes  No

Before Bed Yes  No

Do you take medications that require the monitoring of blood pressure, blood sugar levels or other bodily functions? Yes  No

Do you use any medical appliances eg. CPCP Machine, puffer, nebuliser? Yes  No

If a medical appliance is used and required during a Life Stream program, prior to participation you will need to supply Life Stream with written documentation in regards to the purpose, use of and instructions to ensure the appliance is used correctly.

Is there anything else we should know about your medication? Yes  No

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If you require medication to be administered by Life Stream staff/volunteers during a program, you are required to complete a Life Stream medication form. Please request a form at the time of making a program booking and return the completed form to the office at least 5 days prior to the program date.

## BEHAVIOUR PROFILE

Please describe your general behaviour and social abilities.

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Do you display challenging behaviours? Please describe and suggest strategies used to prevent or respond to these behaviours.

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What are your personal goals relating to accessing Life Stream programs? How can we help you?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Do you have any special needs ie. Religious or ethnic based?

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Life Stream Foundation has a Smoking Policy – please refer to your Member’s Guide or contact the office if you would like a copy of the policy. Members who smoke during Life Stream Foundation programs are required to remove themselves from the group/ program and consequently remove the duty of care ‘supervision’ responsibility from Life Stream Foundation.

Do you smoke? Yes  No

## DAILY LIVING SKILLS

Please circle the response for each category that best describes your daily living skills. **Please provide additional information related to the completion of the task in each category if you are not fully independent.**

### Using Toilet

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_  
\_\_\_\_\_

### Bathing / Showering

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_  
\_\_\_\_\_

**Washing Hair / Shaving**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Dressing / Undressing**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Grooming**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Eating**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Brushing Teeth**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Money Handling**

Fully Independent

Needs Verbal Prompts

Requires Assistance

Details: \_\_\_\_\_

**Communication** (Please circle relevant methods)

Verbal

Auslan

Makaton

Personal Signs Computer

Picture / Word Book

Other: \_\_\_\_\_

**Swimming** - Indicate by ticking one box

- Non Swimmer - Fear of water, won't put face under water, needs assistance at all times
- Little Ability - Will put face under water, can't swim, maximum water depth 1m)
- Water Safe - Able to dog paddle, swim to side of pool, water depth greater than 1m)
- Proficient Ability - Capable and confident, safe in deep water)

Have you had swimming lessons? Yes  No

Details: \_\_\_\_\_

Are you required to wear a buoyancy aid? Yes  No

Details: \_\_\_\_\_

Have you ever had an incident in the water? Yes  No

Details: \_\_\_\_\_

**Alcohol**

At times during our programs if a participant is over the age of 18, you will have access to alcohol.

Are you able to have an alcoholic drink? Yes  No

If yes, please indicate number of drinks and type of drink: \_\_\_\_\_

**Wandering**

Is the participant likely to wander? Yes  No  Possibly  (Easily Distracted)

Is the participant capable of leaving the group for a short time and returning on their own?

Eg. To go to the toilet, to get a drink Yes  No

Please provide any other pertinent details: \_\_\_\_\_

**DIETARY REQUIREMENTS**

Please list any dietary requirements or restrictions:

\_\_\_\_\_  
\_\_\_\_\_

Please list any special needs related to swallowing or chewing food:

\_\_\_\_\_  
\_\_\_\_\_

Do you feel that there is any information that is pertinent to the care and safety of the participant that is not covered in this form? \_\_\_\_\_

How did you learn about Life Stream Foundation?

- Disability Services QLD       Sport & Recreation QLD       Family / Friend  
 Internet Search       School       Special Event / Media       Other: \_\_\_\_\_

## INCLUSION IN PROMOTION CONSENT

From time to time Life Stream will ask members to consent to inclusion in photography and video which may be used in all formats and media, as representations, reproductions or adaptations either complete or in part, alone or in conjunction with any wording or drawing, for all uses including Life Stream advertising and commercial purposes. This also includes a member's photo being displayed on the Life Stream website ([www.lifestream.org.au](http://www.lifestream.org.au)). With this in consideration, please tick one of the following:

- I consent to the above without need for further consent or permission  
 I consent to having my photo displayed on the Life Stream website *only* without need for further consent or permission  
 Please seek my permission on a per-use basis of my photo for promotional purposes  
 I do not consent to the above (Photo will never be used by Life Stream for promotional purposes)

LIFE STREAM's Privacy Policy protects the information collected by this document. This Policy ensures the confidential storage, use and destruction of the information gathered. The information will only be used for the primary purpose of its collection. For more information or for a copy of the Privacy Policy, contact a LIFE STREAM office or visit our website at [www.lifestream.org.au](http://www.lifestream.org.au) to download a copy.

Declaration: I have been provided with a copy of and I agree to the terms of the Member's Guide of Life Stream Foundation, and wish to apply for membership. I agree that all information contained in this form is true and accurate and I agree to inform Life Stream Foundation **immediately** of any changes.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Member or Carer on Members Behalf)

This form was completed by: \_\_\_\_\_

## **CONSENT TO RELEASE OF INFORMATION**

Life Stream Foundation is audited under the Disability Sector Quality System on an annual basis.

Do you consent to your Member file being reviewed by external auditors for quality assurance testing?                       No                       Yes

Do you consent to being named as a candidate for an interview with external auditors for quality assurance testing?                       No                       Yes

Life Stream believes in the confidential collection, storage, release and destruction of personal and sensitive information. Primarily, this policy applies to information held on members accessing Life Stream Foundation services. However, the basic principles also apply to any individual the organisation holds information on.

The main purpose for collecting and distributing personal and health related information regarding members is to ensure Life Stream Foundation meets the duty of care for each individual when participating in programs. Life Stream Foundation approaches its duty of care seriously and the safety of individuals is the ultimate aim in service delivery. The release of personal and health information by the organisation is only to those individuals adopting the duty of care on a program. The information released is also protected by Life Stream Foundation's Confidentiality Agreement, which is accepted and signed by each staff member of the organisation.

At times, Life Stream staff may need to consult other members of your support networks regarding appropriate support needs. This will be completed to ensure that Life Stream is providing an appropriate duty of care. These support networks may include (but not limited to) family, doctors/specialists, other service providers or support workers.

Life Stream requires your permission to contact these people. Please list below the people we can contact:

Members Name: \_\_\_\_\_

1. \_\_\_\_\_  
(Name or organisation) (Phone)

2. \_\_\_\_\_  
(Name or organisation) (Phone)

3. \_\_\_\_\_  
(Name or organisation) (Phone)

4. \_\_\_\_\_  
(Name or organisation) (Phone)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alternatively, please tick this box and Life Stream staff will contact you to gain permission prior to releasing information to stakeholders.

**PAYMENT DETAILS**

**Type of Membership (Please tick)**

**Cost**

- Individual \$25 for full financial year/refer to Member’s Guide for pro-rata rates
- Family \$30 for full financial year/refer to Member’s Guide for pro-rata rates

*NB: EACH TYPE OF MEMBERSHIP ENTITLES THE BEARER TO ONE VOTING RIGHT ONLY*

**PAYMENT METHOD**

- Cash (Please pay at Life Stream office – DO NOT POST CASH)
- Cheque  Money Order (Please make payable to Life Stream Foundation & attach to this application form)
- Direct Deposit (See details below for Direct Deposit to our bank account)
- MasterCard  Visa (A **1.764% surcharge applies to all credit card payments**)

**CARD NUMBER:**    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**NAME ON CARD:**    \_\_\_\_\_

**EXPIRY DATE ON CARD:**    \_\_ / \_\_

**SIGNATURE OF CARD HOLDER:**    \_\_\_\_\_

**DIRECT DEPOSIT DETAILS**

**Bank:** Bank of QLD                   **BSB:** 124 001                   **Account No.:** 106 197 39  
**Account Name:** Life Stream Foundation  
**IMPORTANT:** Please use First Initial & Surname as the reference.

**PAYMENT AMOUNT**

Membership Fee                           \$ \_\_\_\_\_  
3% surcharge if using credit card    \$ \_\_\_\_\_  
Total   \$ \_\_\_\_\_

**OFFICE USE ONLY**

**Support Requirements:**

**File Created and Entered By:**

Name	Position	Date	Signature
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**Reviewed By:**

Name	Position	Date	Signature
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Name	Position	Date	Signature
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