

RESPIRE VISITS APPLICATION FORM (OCCASIONAL SHORT STAY VISITS)

Information that you give on this form will be treated as confidential unless it is clearly necessary to share it to protect your health or safety or the health and safety of others.

NAME:

DATE OF BIRTH:

CURRENT ADDRESS:

CONTACT NUMBER(S)

HOME ADDRESS (if different from above)

HOW DO YOU HOPE THAT COMING FOR VISITS TO PILSDON WILL HELP YOU?

DO YOU HAVE ANY CONCERNS ABOUT YOUR HEALTH AT PRESENT?

WHAT IS THE NAME AND ADDRESS OF YOUR GP?

DO YOU HAVE A SOCIAL WORK, PROBATION OFFICER, COMMUNITY NURSE OR ARE YOU SEEING A SPECIALIST OR OTHER PROFESSIONAL HELP AT PRESENT?

IF SO PLEASE GIVE DETAILS.

HAVE YOU HAD ANY SERIOUS ILLNESSES IN THE PAST? PLEASE GIVE DETAILS.

PLEASE TELL US OF ANY MEDICATION YOU ARE CURRENTLY TAKING.

DO YOU HAVE ANY SPECIAL DIETARY REQUIREMENTS OR ANY MOBILITY OR SPECIAL ACCESS NEEDS?

HAVE YOU GOT/HAD A PROBLEM WITH DRUGS OR ALCOHOL? IF YOU HAVE PLEASE GIVE DETAILS.

IF YOU HAVE A RECORD OF CRIMINAL OFFENCES PLEASE TELL US ABOUT THEM.

HOW DO YOU PLAN TO MEET THE COST OF YOUR VISIT? (2011/12 FULL COSTS ARE £40 FULL-BOARD AND ACCOMMODATION PER DAY.) IT IS POSSIBLE FOR US TO ADJUST THIS SUM DEPENDING ON YOUR RESOURCES; PLEASE DISCUSS THIS WITH US IF NECESSARY.

WHO IS YOUR NEXT OF KIN? PLEASE GIVE DETAILS

FOR EQUAL OPPORTUNITIES MONITORING, PLEASE TELL US YOUR ETHNIC BACKGROUND. DO YOU HAVE ANY RELIGIOUS NEEDS OF WHICH WE SHOULD BE AWARE?

WHAT ARE YOU ABLE TO OFFER TO THE LIFE OF THE COMMUNITY AT PILSDON?

I CERTIFY THE INFORMATION I HAVE GIVEN IS CORRECT AND I UNDERSTAND THAT YOU WILL TAKE UP AT LEAST ONE REFERENCE.

SIGNATURE..... DATE.....

CONSENT FOR RELEASE OF INFORMATION

I consent to the relevant personal information being given to the Pilsdon Community by the persons/organisation named below, for the purpose of my application to that community, on the understanding that any information released to Pilsdon will be treated as confidential.

Signed.....

Date.....

Your Name and Address (please print)

.....
.....
.....
.....

Names and Address of your Doctor, CPN or health professional who best knows you and your circumstances

.....
.....
.....