



Queen Elizabeth Centre
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ABN 23 237 300 347

FATHER / PARTNER'S DETAILS

To assist us in making your admission to the QEC easier for you and your family if the form was sent by QEC, please **place completed forms in prepaid envelope and post back to QEC, prior to your admission date.** If this is not possible, bring the form with you on the day. This information is confidential and use only to provide details needed for your admission.

NAME OF PROGRAM: Residential **Date of Admission** ____/____/____

Medicare No: ____/____/____ **Number listed on Card (eg 1,2,3,)**

Expiry Date ____/____

Surname: _____ Single

Given names: _____ Married

Date of Birth: _____ Separated

Country of birth: _____ State: _____ Divorced

Address: _____ Defacto

_____ Postcode: _____ Widow

Phone Number: (AH) _____ (BH) _____

Language spoken at home: _____ Interpreter Required: YES / NO

Health Care Card No: ____/____/____ **Expiry Date:** ____/____/____

Total number of children _____

FAMILY INCOME: (PLEASE TICK)

- | | |
|---|---|
| <input type="checkbox"/> Carer pension | <input type="checkbox"/> Young homeless allowance |
| <input type="checkbox"/> Disability support pension | <input type="checkbox"/> Sole parent pension |
| <input type="checkbox"/> Employed | <input type="checkbox"/> Other pension / benefit |
| <input type="checkbox"/> Newstart / Jobsearch allowance | <input type="checkbox"/> Family Assistance |
| | <input type="checkbox"/> Family Tax Benefit |

EMERGENCY CONTACT:

Surname: _____ Given Names: _____

Relationship to Client: _____

Address: _____

Postcode: _____
Phone Number: (BH) _____ (AH) _____

MEDICAL DETAILS:

Doctor's Name: _____

Address: _____

Phone No: _____

ABORIGINALITY:

Please tick correct one:

- Not Indigenous- Not Aboriginal or Torres Strait Islander origin
- Indigenous – Aboriginal but not Torres Strait Islander origin
- Indigenous – Torres Strait Islander but not Aboriginal origin
- Indigenous – Aboriginal and Torres Strait Islander origin

PREVIOUS CLIENT:

Have you ever received a service from QEC?

YES / NO

If yes, please indicate service and where it was held:

- | | | | |
|------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Daystay | <input type="checkbox"/> Residential | <input type="checkbox"/> Home Visiting | <input type="checkbox"/> Telephone Advice |
| <input type="checkbox"/> Carlton | <input type="checkbox"/> Noble Park | <input type="checkbox"/> Wangaratta | |
| <input type="checkbox"/> Gippsland | <input type="checkbox"/> Northern | | |

Date of service: _____

DIET: (APPLICABLE TO RESIDENTIAL CLIENTS)

Do you require a special diet? Eg. Vegetarian, Kosher, soy milk, allergies. Please give details and advise Centre prior to admission on: 03 9549 2732.



FAMILY HEALTH DETAILS – FATHER / PARTNER

NAME OF PROGRAM: Residential **Date of Admission** ____/____/____

Father/Partner's Full Name: _____ **Date of birth:** ____/____/____

Medicare No: ____-____-____/____-____-____/____ **Number listed on Card (eg 1,2,3,)** **Expiry Date:** ____/____

1. At present, how would you describe yourself in relation to the following: (Please mark at any place along the line that best indicates how you feel?)
- | | | |
|---|--------------------|------------|
| i. Physical Health | poor _____ | good |
| ii. Sleep pattern | sleep poorly _____ | sleep well |
| iii. Appetite/eating | poor _____ | good |
| iv. Level of communication with partner | poor _____ | excellent |

2. Have you ever had any illness, injury or disability that affects your family life and/or parenthood?
 No Yes, please list them below:

3. Are you currently taking any tablets or medication? No Yes, please list them below:

4. Do you have any known allergies? No Yes, please list below:

5. Do you smoke cigarettes? No Yes, please indicate frequency:

6. Do you drink alcohol? No Yes, please indicate frequency:

7. Do you use other recreational drugs? No Yes, please indicate type and frequency:

8. Have you experienced any major lifestyle event during the past year?

- | | | |
|--|--|--|
| <input type="checkbox"/> Relationship changes | <input type="checkbox"/> Family illness/death | <input type="checkbox"/> Major financial change |
| <input type="checkbox"/> Moving/renovating house | <input type="checkbox"/> Self or Partner return to Study | <input type="checkbox"/> Self or partner loss/change in employment |

9. Who provides the main support for you in your parent role?

10. Please indicate your Education Level

- Year 9-10 VCE or equivalent Undergraduate Degree Graduate Degree Masters Other

11. If you have worked since leaving school, what is your occupation/profession?

CHILD ONE

Name: _____





	Very Happy	Happy	Mixed	Unhappy	Very Unhappy
					

Please circle a number to describe how you feel

- | | | | | | |
|--|---|---|---|---|---|
| 1. How do you feel about the job of being a parent? | 1 | 2 | 3 | 4 | 5 |
| 2. How do you feel with the way you get along with your child? | 1 | 2 | 3 | 4 | 5 |
| 3. How do you feel about the way your child behaves? | 1 | 2 | 3 | 4 | 5 |

CHILD TWO

Name: _____

	Very Happy	Happy	Mixed	Unhappy	Very Unhappy
					

Please circle a number to describe how you feel

- | | | | | | |
|--|---|---|---|---|---|
| 1. How do you feel about the job of being a parent? | 1 | 2 | 3 | 4 | 5 |
| 2. How do you feel with the way you get along with your child? | 1 | 2 | 3 | 4 | 5 |
| 3. How do you feel about the way your child behaves? | 1 | 2 | 3 | 4 | 5 |

This form is completed by

Completed by QEC Staff Member

Name: (Please print) _____

Signature: _____

Date: ____/____/____

Name: _____

Position: _____

Signature: _____

Date: ____/____/____