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ABN 23 237 300 347

MOTHER'S DETAILS

To assist us in making your admission to the QEC easier for you and your family please **place completed forms in Prepaid envelope and post back to QEC, prior to your admission date.**

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

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

Expiry Date ____/____

Mrs / Miss / Ms 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.





HEALTH DETAILS – MOTHER

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

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

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. Please fill in details of your pregnancy/ies.

Year	Planned or Unplanned	Outcome TOP-miscarriage live birth/still birth	Was child born at term?	Type of delivery: Normal, Forceps Caesarean, Breech?

9. Where there any complications during any of the above pregnancies or birth? No Yes

10. 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 |

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

12. Please indicate your Education Level
- | | | | | | |
|------------------------------------|--------------------------------------------|-----------------------------------------------|------------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Year 9-10 | <input type="checkbox"/> VCE or equivalent | <input type="checkbox"/> Undergraduate Degree | <input type="checkbox"/> Graduate Degree | <input type="checkbox"/> Masters | <input type="checkbox"/> Other |
|------------------------------------|--------------------------------------------|-----------------------------------------------|------------------------------------------|----------------------------------|--------------------------------|

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

CHILD ONE

Name: _____

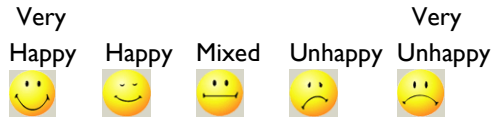


Please circle a number to describe how you feel

- | | | | | | |
|----------------------------------------------------------------|---|---|---|---|---|
| 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: _____



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 |

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 2777.

This form is completed by _____

Completed by QEC Staff Member

Name: _____

Name: _____

Name: (Please print) _____

Position: _____

Signature: _____

Signature: _____

Date: ____/____/____

Date: ____/____/____