Portland Freedom Day Services

CITIZEN APPLICATION FORM

Please place photograph of applicant here

Name of Applicant

Preferred to be known as

Name of person completing the form and their relationship to applicant

SERVICE REQUIRED:

(Please note that Day Service is **open for 50 weeks a year.** We will advise you about our closure weeks each year. We are also closed on Bank Holidays.)

Please tell us the what level of service you require i.e. days/times:

- 50 weeks
- 38 weeks (i.e. term time only)

Monday Tuesday Wednesday Thursday Friday Saturday

Other requirements:

Date form completed

Date place required from

FOR OFFICE USE ONLY

Date Received: _____

Portland
Freedom

HELLO AND WELCOME TO DAY SERVICES & COMMUNITY HUBS

Day Services is all about spending your day in a meaningful way - having more opportunities, developing skills and making new friends.

Our Day Service is a non-residential service that is registered with our Local Authority. The service is delivered from our accessible Day Centre on the Portland campus as well as from hubs in the local community.

The Day Service is available to individuals 17+ with a range of support needs, including physical disabilities, learning disabilities and Autism.

To find out more about what **Portland Day Services** can offer you, call **01623 499111** or email to **dayservicecoordinators@portland.ac.uk**

We will also be able to advise you about our current availability.

CONTACT INFORMATION

Full Name

Known As

Date of Birth

Address

Telephone Number

Email Address

Preferred Method of Contact: Telephone Email Text

Your contact details will be added to our database for surveying and marketing purposes. If you would **NOT** like to be added, please tick here:

NEXT OF KIN

Name

Relationship

Address

Telephone Number

Email Address

Preferred Method of Contact: Telephone Email Text

Your contact details will be added to our database for surveying and marketing purposes. If you would **NOT** like to be added, please tick here:

GP CONTACT

Please provide details of your current GP practice:

Doctors Name:

Address

Telephone Number

Please note: In the case of a medical emergency, Portland College reserves the right to take decisions that would involve contacting our local GP/emergency services due to our duty of care for all citizens and learners.

RELIGIOUS/CULTURAL NEEDS

Please indicate details of any specific personal needs (i.e. prayer, worship, support staff, dietary needs)

MEDICAL

NHS Number

Medical Exemption Number

National Insurance Number

SOCIAL WORKER (if you currently have an allocated worker)

Name

Address

Telephone

Email

LIVING WELL TEAM (if you do **NOT** currently have an allocated social worker)

Name

Address

Telephone

Email

INFORMATION ABOUT YOU

Your disability:

How does this affect your daily life?

Please tell us about your personality, including your likes and dislikes:

Who, or what, is important to you?

Do you have a disabled person's bus pass? Yes No

If yes, is it with a companion? Yes No

What are your expectations of your time at Portland Day Services ?

What are your goals for your time at Portland Day Services ?

BEHAVIOUR

Please describe some examples of any behaviours that may challenge yourself and others.(please include all levels of behaviour)

When was the last occurrence of behaviour?

What triggers this behaviour? (f.e. environment, peers, changes to routine etc)

How often do these behaviours occur?

Occasionally Often Very Often

What are the early signs that staff need to be aware of before any behaviours occur? (pacing, crying, change in facial expression etc)

What strategies help to support with the behaviour to try and stop it? (e.g calm approach, reinforcements/rewards, proactive strategies, reactive strategies)

What will make the behaviour worse?

What helps staff to motivate you to stop the behaviours happening? (how do you like to be supported?)

How do you like staff to support after any behaviour? (post incident support)

BEHAVIOUR continued

Do you have a Behaviour Support Plan? Yes No

If yes, please ensure you enclose a copy of this.

Have you had any contact or support from any external services? (including CAMHS Child and Adolescent Mental Health Services, Psychology, Psychiatry, ICATT Intensive Community Assessment and Treatment Team) Yes No

If the answer is yes to the above question, please provide contact details:

Contact name:

Service: Job role:

Address:

Telephone: Email:

Contact name:

Service: Job role:

Address:

Telephone: Email:

Please provide any other information about your behaviour that you feel would be useful to accompany this application:

SAFEGUARDING RISKS

Are there any risks associated with the following?

Vulnerability - risks associated with being subjected to potentially abusive situations, stranger danger etc

Awareness of dangerous situations - risk associated with being unaware of dangerous situations e.g. road safety, or using equipment

Interactions with other learners - risks associated with interactions with other learners, sexual boundaries, online interactions, being a trigger for others

Absconding - risks associated with absconding from different environments

Are there any current or historic safeguarding concerns we need to be aware of?

If you do not want to document any of these safeguarding concerns, would you like a phone call discussion with a member of the Safeguarding team?

MEDICAL HISTORY

Do you have a history of any of the following?
Please give all relevant information in the spaces provided.

Epilepsy

How often Do you have a seizure?

What type of seizures do you have?

How long do the seizures last?

What intervention do you require?

Do you recognise when you are going to have a seizure? Yes No

If yes, please specify how:

Please provide a copy of your current Epilepsy protocol and/or rescue plan with your application

Diabetes
Heart Problems
Mental Health Problems
Depression
Anxiety
Asthma
High Blood Pressure
Eating Disorders (e.g Anorexia/Bulimia)

Breathing Difficulties
(e.g Tracheotomy/Oxygen/Restriction/Repeated Chest Infections)

Others (e.g botox/spinal rods/tendon releases/hip displacements etc)

Please provide full details of any of the above:

Has there been a Power of Attorney applied for on behalf of the individual named on the application form? Yes No

If yes please enclose the original documentation

MEDICAL INFORMATION

Medication Prescribed:	How I take this medication
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please ensure all medications are in date, closed, in the correct packaging and with the prescription label intact and fully legible.

Do you understand why you are taking this medication? ☐ Yes ☐ No

Do you have any PRN or emergency medication? (please provide details)

Allergies/drug sensitivity (e.g foods/pollens/animals/latex)

Do Not Attempt Resuscitation (DNAR) order in place? ☐ Yes ☐ No

If yes, please ensure you provide us with a copy.

COMMUNICATION

Are you currently seeing a Speech and Language Therapist? Yes ☐ No ☐

Have you got an individual communication plan? Yes ☐ No ☐

If **YES,** please ensure you enclose a copy of this

What Are you currently seeing a Speech and Language Therapist for? (e.g. speech, using signing)

Do you enjoy communicating and spending time with others, or do you find this difficult?

Do you have difficulties understanding: (please tick all those that apply)

- ☐ Spoken Language
- ☐ What is happening around you

Please give any details:

Do any of the following things help you to understand: (please tick all that apply)

- ☐ Objects
- ☐ Photos
- ☐ Pictures
- ☐ Symbols
- ☐ Signing
- ☐ Single Words
- ☐ Short Sentences

Please give any details:

How do you express yourself or get your message across?

- ☐ Body Language
- ☐ Facial Expression
- ☐ Vocalisation
- ☐ Single Words
- ☐ Short Sentences
- ☐ Fuller Sentences
- ☐ Pictures/Photos
- ☐ Symbols
- ☐ Objects
- ☐ Communication Aid
- ☐ Speaking Switches
- ☐ Speaking Buttons

COMMUNICATION

If you use a communication aid, please provide the following details:
(If you do not have a Communication Aid, please feel free to leave this section blank)

Communication Equipment Details	Funded/ Owned by	Age	Warranty/ Insurance details

How do you access your Communication Aid?

- Eye Gaze
- Switch (Head/foot)
- Head Pointing
- Direct Access (touch)

How do you communicate your basic needs or wants? (i.e. Yes/No, I want, help me, go away etc)

How do you tell us when you are feeling thirsty/hungry/tired/happy/angry/in pain etc?

ASSISTIVE TECHNOLOGY

How do you access computers?

- Switch
- Eye Gaze
- Hands
- Fingers (even one at a time)

What equipment do you use?

- Standard keyboard
- Joy Stick Mouse
- Rollerball Mouse
- On Screen Keyboard
- Big Keys Board
- Standard Mouse

Other

Do you use any specialist software?

- Grid 2 or 3
- Clicker
- Dragon (dictation)
- Dolphin
- Windows accessibility features e.g magnifier

Other

EATING & DRINKING - MEAL TIME SUPPORT

Do you have any special dietary needs i.e. vegetarian, halal, diabetic, modified foods, etc

Yes No

If yes, please provide details:

Do you have or have you ever had any problems with chewing and swallowing?

Yes No

If yes, please provide details:

Do you have any specific likes or dislikes with eating or drinking? Please give details.

Do you require any changes to ordinary food textures and fluids? Yes No

If **YES**, please provide details?

Do you require any specific utensils for eating and drinking? Please give details. (e.g. special cups, size of cutlery used etc)

Please give a brief description of how you like carers to support you with eating and drinking. (e.g whether they should be at your right or left side, the pace at which you like to be given food, whether you like a drink between mouthfuls of food etc)

What is the best position for you to be in when eating and drinking? (e.g. in a manual wheelchair with head rest on, facing away from distraction in the room etc)

Do you have any foods/fluids via enteral nutrition (i.e. PEG, Notube)? Yes No

If YES, please attach your current Enteral Feeding Regime:

OCCUPATIONAL THERAPY

Do you currently have, or have you previously received Occupational Therapy Support?

Yes No

If yes, what for? Please provide contact details for your Occupational Therapist:

Equipment

Do you require specialist seating? Yes No

Do you require any adapted toileting equipment? Yes No

If you answered yes to either of the previous questions, please provide details:

Does this equipment belong to you? If No, tell us to whom:

Do you currently use any other adapted equipment? Please detail below:

Sensory

Do you have any sensory processing difficulties that may affect your learning? (e.g. not liking/needing lots of touch, movement, noise, etc?) Yes No

If yes, please provide details below and complete the **Sensory Choice Checklist** on next page.

Do you require any sensory equipment (f.e. ear defenders, fidget items etc.)? Yes No

If yes, please provide details below.

Do you have any existing sensory strategies (f.e. movement breaks, prompt cards, deep pressure etc.)? Yes No

If yes, please provide details below.

OCCUPATIONAL THERAPY continued

SENSORY CHOICES CHECKLIST

Below are some questions related to each of the body's senses - please answer these and give as much detail as you are able.

There are also some activities listed that many people use daily to keep themselves **calm** or **alert.**

Please mark anything you like with a **Y** and anything you dislike with an **X**. Then mark the items you find calming with a **C**.

TASTE

Could you be described as a 'picky eater'?	Yes	No
Do you chew or put inedible items in your mouth?	Yes	No
Do you dislike the feel of things in your mouth? e.g toothbrush, certain textured food.	Yes	No

Further details/comments:

Activities:

- Drinking through a straw
- Sucking inside of cheeks
- Grinding teeth
- Crunching/sucking ice
- Chewing gum
- Chewing a chewy sweet
- Chewing clothing
- Blowing bubbles
- Sucking on a lollypop
- Drinking through a sports bottle
- Sucking/licking/biting lips
- Clenching jaw
- Crunching crispy foods
- Chewing a toothpick
- Chewing pen/pencil
- Biting nails/hair
- Whistling

OCCUPATIONAL THERAPY continued

SMELL

Do every day smells affect you? ☐ Yes ☐ No

(f.e. petrol smells, food smells)

Do you smell objects/others? ☐ Yes ☐ No

Further details/comments:

Activities:

- ☐ Lavender
- ☐ Smelly pens/stickers
- ☐ Grass
- ☐ Sweet / citrus food smells
- ☐ Aromatherapy
- ☐ Animals
- ☐ Strong food smells (e.g. curry, fried food)
- ☐ Perfume

MOVEMENT

Do you experience motion sickness? ☐ Yes ☐ No

Do you seek out movement? ☐ Yes ☐ No

e.g. can't sit still, fidgets, rocks, paces.

Further details/comments:

Activities:

- ☐ Doodle whilst listening
- ☐ Sitting in a rocking chair
- ☐ Dancing
- ☐ Jiggling leg
- ☐ Swaying body side to side
- ☐ Rocking body
- ☐ Jumping/bouncing
- ☐ Pacing
- ☐ Tapping toe, heel or foot
- ☐ Sitting on an exercise ball

OCCUPATIONAL THERAPY continued

TOUCH

Do you regularly touch people and objects? Yes ☐ No ☐

Do you dislike being touched? Yes ☐ No ☐

Further details/comments:

Activities:

- ☐ Twiddling hair
- ☐ Being tickled
- ☐ Having hair washed
- ☐ Stroking an animal
- ☐ Playing in a sand pit
- ☐ Picking at nails/skin
- ☐ Walking bare foot
- ☐ Drumming fingers or pencil
- ☐ Fiddling with objects (e.g. pen)
- ☐ Having a massage
- ☐ Touching fluffy/velvety fabric
- ☐ Tight fitted clothing
- ☐ Water play
- ☐ Pulling at clothes
- ☐ Rubbing skin/clothing gently

BODY AWARENESS

Do you bump into stationary objects? f.e. walls, doors, lampposts. Yes ☐ No ☐

Do you seek out activities that involve deep pressure? Yes ☐ No ☐

Do you walk with heavy steps? Yes ☐ No ☐

Are you aware of when you are in pain? Yes ☐ No ☐

Do you know when you are too hot or cold? Yes ☐ No ☐

Further details/comments:

Activities:

- ☐ Yoga
- ☐ Walking along balance beams
- ☐ Throwing and catching a ball
- ☐ Hop scotch
- ☐ Using weighted equipment
- ☐ Walking along stepping stones
- ☐ Kicking a ball
- ☐ Boccia

OCCUPATIONAL THERAPY continued

SIGHT

Do you have difficulty adapting to bright light more than others? (e.g. squint, cover eyes in daylight)? Yes ☐ No ☐

Are you easily distracted by watching objects or people move around a room? Yes ☐ No ☐

Do you seek visual stimuli, e.g. looking at lava lamp, fibre optic lights, dim lighting in dark spaces etc? Yes ☐ No ☐

Further details/comments:

HEARING/NOISE

Do you respond emotionally/aggressively to unexpected or loud noises? Yes ☐ No ☐

Are you overly affected by background noise? Yes ☐ No ☐

Further details/comments:

Activities:

- ☐ Make noise for noise sake
- ☐ Wearing headphones to listen to music
- ☐ Time in a quiet space
- ☐ Covering ears with hands
- ☐ Hearing alarm
- ☐ Noise making items
- ☐ Hearing thunder
- ☐ Wearing headphones/ear defenders/ ear plugs to block out noise
- ☐ Listening to music

OCCUPATIONAL THERAPY continued

Fine Motor

Do you have any difficulties related to your fine motor skills? Yes No

If yes, please provide details:

Zips Handwriting Buttons Shoelaces

Using cutlery Other Classroom activities (including cooking)

Do you have any adapted equipment/garments to help you to complete everyday activities (e.g. adapted cutlery, writing slope, pen grips, Velcro shoes etc.)?

TRAVEL TRAINING

Do you have any previous experience of Travel Training? Yes No

Do you feel that you would be able to travel independently in the future? Yes No

Are there any risks or concerns about accessing the community? Yes No

Do you have any difficulties with the following skillls ?

Road Safety Yes No Stranger danger Yes No

Money management Yes No Time management Yes No

Problem solving Yes No

If answered yes to any of these questions, please provide further details:

EMPLOYABILITY

Do you have any previous work experience? Yes No

Would you like to complete work in the future (paid/unpaid)? Yes No

Retail / Customer Service Hospitality (Coffee Shop) Office / Admin

Outdoor / Gardening Health & Social Care Sports / Leisure

Other: please state

Do you have any interest in completing Adult Learning in the future ? Yes No

PHYSIOTHERAPY

If you are currently seeing a Physiotherapist please provide their contact details:

How do you usually get around?

Do you need assistance to get around? (e.g pushing of wheelchair, supervision when walking/driving)

Yes No

If yes, please provide details:

Current physiotherapy goals or things to work towards:

Equipment

Do you use any equipment to help you get around other than a wheelchair?

Orthotics Stick Standing Frame Trike

Walking Frame

If **yes** to any of the above, or if you use any other equipment not listed, please detail below, including if you will be bringing any of this equipment with you to the Day Service.

MOBILITY

How do you transfer from the chair or bed? Please provide details.

Do you need any equipment or assistance to transfer?

Yes No

If yes, please provide details:

PAIN

If you have pain on a regular basis, please supply us with the following information:

Where is it?

How often?

How would you describe it?

How do you relieve your pain?

On the scale below (0 being no pain, and 5 being pain that makes you cry) please mark your pain:

At its best:	0	1	2	3	4	5
At its worst:	0	1	2	3	4	5

Any comments:

HEARING AND VISION

Do you have any hearing problems? Yes No

If so, do you have a hearing aid? Yes No

If yes to either question, please provide details.

Do you wear glasses? Yes No

If so, when do you wear them?

Do you have any other visual difficulties? Yes No

If yes, please provide details:

PERSONAL CARE NEEDS

Do you require any support with personal care? Yes No

Do you use any continence wear? Yes No

Please provide full details of any of the above:

Are you able to direct your care needs? Yes No

EQUAL OPPORTUNITIES

For monitoring purposes only

I describe my ethnic background as: (please tick relevant box)

White

- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any Other White background

Mixed/Multiple Ethnic Group

- White and Black Caribbean
- White and Black African
- White and Asian
- Any Other Mixed/Multiple Ethic background

Asian/Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any Other Asian background

Black/African/Caribbean/Black British

- African
- Caribbean
- Any Other Black/African/ Caribbean background

Other Ethnic Group

- Arab
- Any Other Ethnic Group

Age group:

- 25 and under
- 26-34
- 35-44
- 45-54
- 55-64
- 65+
- Prefer not to say

The capture of this data is a requirement of both Ofsted and CQC, and as a college we have to provide data of our learner cohort. The college Privacy Policy can be access on our website: **www.portland.ac.uk**
A Learner Privacy Policy is available on request from the college's Data Manager.

EQUAL OPPORTUNITIES continued

For monitoring purposes only

How would you define your gender:

- ☐ Man
- ☐ Woman
- ☐ Prefer not to say
- ☐ Other (Please specify)

Marital status:

- ☐ Single
- ☐ Married
- ☐ Civil Partnership
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Prefer not to say

Sexual orientation

- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Straight
- ☐ Prefer not to say
- ☐ Applicant does not have the capacity
- ☐ Other (Please specify)

Religion or belief

- ☐ Christian
- ☐ Muslim
- ☐ Buddhist
- ☐ Sikh
- ☐ Hindu
- ☐ Jewish
- ☐ None
- ☐ Prefer not to say
- ☐ Other (Please specify)

CONSENT

We now require the individual's consent/parental consent through best interests to access confidential information and the most recent Community Care Assessment (CCA) from your local authority.

- ☐ I consent to my son/daughter's CCA to be shared with Portland College.
- ☐ I consent to my CCA to be shared with Portland College.

Name of Citizen

Date of Birth

Parent/Care Name

Relationship to Citizen

Date

Signature

The capture of this data is a requirement of both Ofsted and CQC, and as a college we have to provide data of our learner cohort. The college Privacy Policy can be access on our website: **www.portland.ac.uk** A Learner Privacy Policy is available on request from the college's Data Manager.