Application for Services

PEBBLES: Continence Management Service for People with Disabilities

PEBBLES is a state-wide program that provides support and management for children and adults with disabilities who have toileting and continence issues. PEBBLES provides professional advice and management of toilet training, day wetting, nocturnal enuresis, constipation, faecal incontinence and toileting issues. PEBBLES is managed by Therapy Focus.

Services are tailored to include:

- Assessment of readiness for toilet training
- Toilet training programs and support
- Assessment and management of sensory issues affecting toileting
- Assessment, advice and prescription of continence products (eg nappies, pull-ups and pads)
- Advice and management of toilet training and bladder and bowel health issues including day wetting, bed wetting, constipation, faecal incontinence/soiling
- Referral to subsidy schemes (where the person meets the eligibility conditions)
- Referrals to other services as required
- Information and education for the client/family
- Education and training for health care professionals, education and childcare providers

Services are delivered by a team of healthcare professionals including physiotherapists, occupational therapists, registered nurses, dieticians, psychologist and a therapy assistant. Our staff has a wealth of knowledge in children's and adult's continence issues and disability.

The PEBBLES team work in collaboration with families, education staff, therapists and other health care professionals. Advice and support is also provided to other family members, carers and support workers who require assistance or support with the person's toileting issues or continence management program.

PEBBLES services are delivered via home and school visits, as well as from clinics in metropolitan and regional areas.

If you have any queries or need assistance to complete this form please contact our friendly administration staff on 1300 865 401 or email pebblesadmin@therapyfocus.org.au

Has the applicant ever received services from Therapy Focus / PEBBLES? ☐ Yes ☐ No

If Yes, please contact our friendly administration team before filling in this form to check what details we need from you. Please contact us on the telephone number or email address above.

Please return this form using any of the options below:

1. **Email**: pebblesadmin@therapyfocus.org.au
2. **Fax**: (08) 9451 5480
3. **Post**: PO Box 20 BENTLEY WA 6982

General and appointment enquiries: 1300 865 401

Storage, Access and Correction of Personal Information

All Disability Professional Service Providers are bound by the *Privacy Act 1988*. As such, **Therapy Focus** undertakes to adhere to the National Privacy Principles which regulate how we may collect, use, disclose and store personal information and how individuals may access and correct personal information held about them. For more information about how privacy is managed at Therapy Focus, please visit our website at www.therapyfocus.org.au

Section 1: Funding

PEBBLES provide services funded by the following; please indicate which one applies to you or the applicant:

☐ Government funded specialist disability services funded by the Disability Services Commission (DSC) *(see eligibility criteria below)*
☐ National Disability Insurance Scheme (NDIS)
☐ WA NDIS (WA State Government)
☐ Compensation (please complete Section: 5)

To access this service, continence or toilet training issues need to be included on the applicant's NDIS plan.

If you are not sure which funding applies to you or the applicant or you need assistance to fill out this form please contact our administration officer on 1300 865 401 or email pebblesadmin@therapyfocus.org.au

☐ **Commonwealth Government National Disability Insurance Scheme (NDIS) funding**
To be eligible for NDIS funded services the applicant must live in an NDIS trial site, meet the NDIS eligibility criteria and have an approved NDIS Plan. Please refer to the NDIS website (www.ndis.gov.au) for further information about eligibility.

NDIS participant number: ______________________________

Plan start date: ___ / ___ / ___ (dd/mm/yy)

Please attach a copy of the applicant's NDIS Plan

☐ **WA State Government National Disability Insurance Scheme (NDIS) funding**
To be eligible for WA NDIS funded services the applicant must live in a WA NDIS trial site, meet the WA NDIS eligibility criteria and have an approved WA NDIS Plan. Please refer to the WA NDIS website http://disability.wa.gov.au/wa-ndis-my-way/wa-ndis-my-way/ for further information about eligibility.

WA NDIS participant number:

Plan start date: ___ / ___ / ___ (dd/mm/yy)

Please attach a copy of the applicant's WA NDIS Plan

☐ **Disability Services Commission (DSC) funding**
To be eligible for Therapy Focus' Government funded specialist disability services the applicant must meet the following criteria:

1. Be legally entitled to permanently live in Australia
2. Permanently live in Western Australia
3. Have a disability as defined by the Disability Services Act 1993 or a developmental delay (for children under the age of 8)
4. Have physical, social, learning and/or communication needs arising from the disability, which severely limit their ability to participate in home, community and school

A copy of the eligibility letter provided by DSC will be accepted as proof of meeting the above criteria, otherwise please complete Section: 10 and provide supporting documentation.

What happens next?

Once the Application for Services and the supporting documentation have been received and processed this information is forwarded to our clinical team members. Within 2 weeks' of receiving the processed referral information, one of our clinicians will call you to ask more detailed questions about your / the Applicant's bladder and bowel function. Following the phone call, we will be able to provide you with further information about when an appointment will be scheduled.

Section 2: Applicant Information

Given name: Surname:

Preferred name: Date of birth:

Gender: ☐ Female ☐ Male ☐ Other

Home address:

Suburb: Postcode:

Postal Address: ☐ Same as Home Address

Region: (Office use only)

Country of birth:

Spoken language: ☐ English ☐ Other

Interpreter required: ☐ Yes – for non-spoken communication (e.g. Auslan)

☐ Yes – language/dialect ____

☐ Female ☐ Male ☐ Either

☐ None required

Please provide details of the person completing this form, if different to the Applicant/Parent/Carer/Guardian

Name:

Title/Designation:

Organisation:

Postal Address:

Email address:

Phone No: Mobile No:

Section 3: Next of Kin / Emergency Contact Information

Primary Contact

First Name: Surname:

Relationship to Applicant:

Address: ☐ Same as Applicant

Home Phone: Work Phone:

Mobile:

Email:

Spoken language: ☐ English ☐ Other:

Interpreter required: ☐ Yes – for non-spoken communication (e.g. Auslan)
☐ Yes –language/dialect ____________________
☐ Female ☐ Male ☐ Either
☐ None required

Alternative Contact

First Name: Surname:

Relationship to Applicant:

Address: ☐ Same as Applicant

Home Phone: Work Phone:

Mobile:

Email:

Preferred contact method: ☐ Mobile ☐ Phone ☐ Email ☐ Post

Spoken language: ☐ English ☐ Other:

Interpreter required: ☐ Yes – for non-spoken communication (e.g. Auslan)
☐ Yes –language/dialect ____________________
☐ Female ☐ Male ☐ Either
☐ None required

Section 4: Legal Guardianship

Does the Applicant have a legal guardian? ☐ Yes (please provide details below) ☐ No **(go to section 5)**

Name:

Agency:

Postal address:

Phone: Mobile:

Email address:

Preferred contact method: ☐ Mobile ☐ Phone ☐ Email ☐ Post

Spoken language: ☐ English ☐ Other:

Interpreter required: ☐ Yes – for non-spoken communication (e.g. Auslan)

☐ Yes –language/dialect ____

☐ Female ☐ Male ☐ Either

☐ None required

	Please tick (✓) if any of these orders are in place	Please tick (✓) if any of these are in administered by the State Administration Tribunal
Guardianship	☐	☐
Administration	☐	☐
Power of Attorney	☐	☐
Enduring Power of Attorney	☐	☐

Section 5: Compensation

Is the Applicant seeking compensation for their disability: ☐ Yes ☐ No

Is the Applicant currently **receiving** compensation for their disability: ☐ Yes ☐ No

If you answered **Yes** to either of the above please give details below. If you answered **No** to both, go to **Section 6**

Insurance Agency:

Claim No:

Claim Manager: Phone No:

Postal or email address:

Solicitor's Agency:

Solicitor's name: Phone No:

Postal or email address:

Section 6: Disability

What is the Service User's **primary/main** disability? **Please tick (✓) one box only:**

- ☐ Acquired Brain Injury
- ☐ Specific Learning – other than Intellectual
- ☐ Autism Spectrum Disorder
- ☐ Intellectual
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para / quadri (tetra) / hemiplegia
- ☐ Spina Bifida
- ☐ Psychiatric Disability
- ☐ Deaf blind – dual sensory
- ☐ Vision
- ☐ Hearing
- ☐ Speech Impairment
- ☐ Other (please specify) ____

The *Disability Services Act 1993* defines disability as a condition that is*:*

- attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of those impairments;
- is permanent or likely to be permanent; and
- may or may not be episodic in nature;

and results in:

- a substantially reduced capacity of the person, the communication, social interaction, learning or mobility ; and
- a need for continuing support services

Does the Service User have any **other** disability? – **you may tick (✓) more than one box:**

- ☐ Acquired Brain Injury
- ☐ Specific Learning – other than Intellectual
- ☐ Autism Spectrum Disorder
- ☐ Intellectual
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para / quadri (tetra) / hemiplegia
- ☐ Spina Bifida
- ☐ Psychiatric Disability
- ☐ Deaf blind – dual sensory
- ☐ Vision
- ☐ Hearing
- ☐ Speech Impairment
- ☐ Other (please specify)

Section 7: Health

Disability/Medical Diagnosis

Does the Applicant need advice or management regarding: P*lease tick (√) all that apply*

- ☐ Day wetting
- ☐ Nocturnal enuresis/ bedwetting
- ☐ Sensory issues
- ☐ Constipation
- ☐ Faecal incontinence /soiling
- ☐ Behavioural issues around toileting
- ☐ Toilet training
- ☐ Nappies / continence products
- ☐ Urinary retention
- ☐ Other – (***please specify***)

Please describe the main concern (e.g., incontinence, soiling, need for assistance with toilet training)

Is the Applicant a past or current patient of:

- ☐ Continence Clinic at PMH
- ☐ Spinal Rehabilitation Clinic at PMH
- ☐ Other continence clinic
- ☐ Urology Clinic
- ☐ Colorectal Clinic
- ☐ Gastroenterology Clinic
- ☐ Gynaecology Clinic

If you have ticked any of the above boxes please provide details below:

____

____

____

____

Is the Applicant currently taking any medicines or supplements for bladder and bowel problems?

Please list medicines taken

____

____

____

These medications were prescribed by:

Doctor/Specialist Name:

Medical Centre Name:

Address:

Phone No: Fax:

If the Applicant has an Occupational Therapist please provide details:

Name of OT:

Organisation:

Email:

Work Phone: Mobile:

Is the Applicant receiving therapy services from any other provider/s? ☐ Yes ☐ No

If Yes, please provide details:

Provider 1:

Name:

Organisation: Designation:

Email:

Work Phone: Mobile:

Provider 2:

Name:

Organisation: Designation:

Email:

Work Phone: Mobile:

Section 8: Help and Supervision

Please indicate the level of help or supervision required in each life area in rows (a) to (i)

Tick only one level of help or supervision in columns 1-4

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

Please answer the following if the Applicant is 5 years old or over:

	1. Unable to do or always needs help/supervision	**2.** Sometimes needs help/supervision	**3.** Does not need help but uses aids/equipment	**4.** Does not need help and does not use aids/equipment
a)Self Care Ability to wash, dress, eat, drink and go to the toilet.	☐	☐	☐	☐
	Please describe help/equipment needed:			
b)Mobility Ability to move around and get in/out of a bed or a chair.	☐	☐	☐	☐
	Please describe help/equipment needed:			
c)Communication Ability to be understood and communicate with others.	☐	☐	☐	☐
	Please describe help/equipment needed:			
d)Interpersonal relationships Ability to make and keep friendships, display socially acceptable behaviour and cope with feelings.	☐	☐	☐	☐
	Please describe help/equipment needed:			
e) Learning Ability to solve problems, make decisions and apply learning.	☐	☐	☐	☐
	Please describe help/equipment needed:			

	1. Unable to do or always needs help/supervision	2. Sometimes needs help/supervision	3. Does not need help but uses aids/equipment	4. Does not need help and does not use aids/equipment
f)Education Ability to engage at school/university, take direction from teachers, study and complete tasks and projects.	☐	☐	☐	☐
	Please describe help/equipment needed:			
g)Community Participation Ability to engage in organized community activities and use private and/or public transport.	☐	☐	☐	☐
	Please describe help/equipment needed:			
h)Domestic Life Ability to live independently, maintain a homecare for personal objects and acquire food, clothing and other necessities.	☐	☐	☐	☐
	Please describe help/equipment needed:			
i)Work skills: Ability to engage in all aspects of employment including organised work activities, required tasks and attending work on time.	☐	☐	☐	☐
	Please describe help/equipment needed:			

Does the Applicant attend any of the following? *Please tick (✓) all that apply*

☐ Day Care	☐ Kindy	☐ Respite	☐ After School Care
☐ School	☐ Home school	☐ Vacation Care	☐ Work Place

Name:

Address:

Phone No: Mobile:

School Year: Teacher/Supervisor:

Name of Centre:

Days attending:

Please provide details of GP/Family Doctor or Specialist involved in the Applicant's bladder and/or bowel management if not already provided

Name of Doctor

Medical Centre Name:

Address or Department:

Phone No: Fax No:

Please provide details of other agencies involved in the Applicant's care

Organisation

Contact Name:

Phone No: Fax No:

Section 9: Consent

To assist in prompt processing of this form please provide consent to allow for sharing of information and providing services as below

Consent to Exchange Information: (Please tick (✓) as appropriate)

I/We give consent for:

- ☐ the Applicant to receive services from PEBBLES (**NB**: PEBBLES is a program managed by Therapy Focus).
- ☐ PEBBLES to contact the Applicant's Family Doctor/General Practitioner and Medical Specialist/s to exchange information including reports.
- ☐ information regarding the Applicant to be shared between the Planner and PEBBLES.
- ☐ PEBBLES to exchange information with **all the other agencies, service providers and health care professionals** listed on this form.
- ☐ the Applicant to receive services from students supervised by PEBBLES staff members.
- ☐ PEBBLES to use the Applicant's personal information in de-identified form for research purposes, including the presentation of such information at public seminars and conferences and in relevant publications.
- ☐ Therapy Focus to send me appointment reminder messages via SMS.
- ☐ news, event information and other updates to be sent to me from Therapy Focus

I/We understand that this consent remains valid while the Applicant is receiving services from PEBBLES and I/We agree to notify PEBBLES of any changes which may affect this consent.

Printed Name:

Signature:

Date:

Printed Name:

Signature:

Date:

Application Checklist

Please ensure the following sections have been completed:

- ☐ 1. Funding
- ☐ 2. Applicant Information
- ☐ 3. Next of Kin / Emergency Contact Information
- ☐ 4. Legal Guardianship
- ☐ 5. Compensation
- ☐ 6. Disability
- ☐ 7. Health
- ☐ 8. Help and Supervision
- ☐ 9. Consents
- ☐ 10. Client Data Collection (for DSC funded applicants only) **see pages 15 and 16**

Supporting documentation attached (if applicable):

- ☐ 1. Evidence of Australian Permanent Residency (i.e. Australian birth certificate, Australian Citizenship Certificate, passport)
- ☐ 2. Evidence of permanent residency in Western Australia (i.e. phone bill, electricity bill, car registration)
- ☐ 3. Evidence of Diagnosis (i.e. report from a general practitioner or specialist stating diagnosis)
- ☐ 4. Copy of applicant's Disability Services Commission eligibility letter (accepted in place of points 1-3)
- ☐ 5. Copy of applicant's NDIS / WA NDIS Plan
- ☐ 6. Evidence of Health (optional)
- ☐ 7. Evidence of Help and Supervision (optional)

Section 10: Client Data Collection

(for DSC funded applicants **ONLY** – not required if the Applicant is or has been a client of Therapy Focus)

Therapy Focus is required to release information to the Disability Services Commission and the Australian Institute of Health and Welfare for statistical purposes. The information is kept confidential and will not affect the applicant's entitlements or access to Therapy Focus services. Please select ( ) one box only per question.

What is the applicant's Aboriginal status?

- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin

What is the applicant's most effective form of communication?

- ☐ Not known
- ☐ Not applicable as the applicant is aged 5 or under as at 30 June
- ☐ Little or no effective communication
- ☐ Other effective non-spoken communication
- ☐ Sign language (effective)
- ☐ Spoken language (effective)

Who does the applicant live with?

- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with others

What is the applicant's residential setting?

- ☐ Other
- ☐ Private residence
- ☐ Residence with an Aboriginal/Torres Strait Islander community
- ☐ Short term crisis accommodation or transitional accommodation
- ☐ Supported accommodation facility (e.g. hostels)
- ☐ Supported living facility domestic scale (e.g. group homes)

What is the applicant's employment status?
(Only for those aged 15 or above, and those who turn 15 before 1 July)

- ☐ Employed
- ☐ Unemployed
- ☐ Not looking for work
- ☐ Still at school

What is the applicant's main source of income?
(Only for those aged 16 or above, and those who turn 16 before 1 July)

- ☐ Disability Support Pension
- ☐ Other pension or benefit (not superannuation)
- ☐ Receiving compensation
- ☐ Other (superannuation, investment)
- ☐ Paid employment
- ☐ Nil income from any source

Informal carers are parents, family or friends who provide assistance to the service user on an ongoing basis and might receive a benefit or pension for providing care.

Does the applicant have an **informal** carer who regularly provides assistance? ☐ Yes ☐ No

Does the applicant's carer/parent receive Carer's Allowance from Centrelink? ☐ Yes ☐ No

Only answer the questions below if you responded YES to the first question above.

Does the MAIN informal carer live in the same household as the applicant? ☐ Yes ☐ No

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What is the relationship of the informal carer to the applicant?

☐ Mother

☐ Father

☐ Female friend/neighbour

☐ Not known

☐ Other female relative

☐ Other male relative

☐ Male friend/neighbour

Which age group best describes the informal carer of the service user?

☐ Under 15 years

☐ 15 – 24 years

☐ 25 – 44 years

☐ 45 – 64 years

☐ 65 – 69 years

☐ 70 years and over

☐ Not known