

To ensure we are able to provide the most appropriate support for you, we are required to gather personal, medical and statistical data, which may be used to report back as de-identified information to the Australian Government. Please complete the information below in as complete detail as possible and return this form in person to 25 King William Rd UNLEY, post to Locked Bag 1 REGENCY PARK SA 5010 or email to contactus@fightingparkinsons.org.au.

PERSONAL DETAILS

Full Name: _____ Date of Birth: / /

Gender Identity: Male Female Non-Binary Other: _____

Address: _____

Mobile/Phone Number: _____ Email Address: _____

Country of Birth: _____ Cultural Identity/Ancestry: _____

Language Spoken: _____ Interpreter Required? Yes No

Do you identify as: Aboriginal Torres Strait Islander Neither I prefer not to say

I am a person with/who has had a: (please tick relevant box) Parkinson's disease Stroke Dystonia

Progressive Supranuclear Palsy (PSP) Essential Tremor Lewy Body Dementia (LBD)

Multiple System Atrophy (MSA) Corticobasal Degeneration (CBD)

Other Neurological/Movement Disorder

When were you diagnosed? / /

Medicare Card No: _____ Individual Reference No: _____

GP/Clinic Name: _____ Phone No: _____ Fax No: _____

GP/Clinic Address: _____

Do you see a Specialist? Yes - A Neurologist Yes - A Geriatrician No

Specialist Name: _____ Phone No: _____ Fax No: _____

Specialist Address: _____

FUNDING SUPPORTS AND LIVING ARRANGEMENTS

Source of Income: Pension - Aged Disability Carer Payment Jobseeker/Newstart
DVA Gold DVA White DVA Other Self funded

Do you receive funding supports for daily living? Yes No

If yes please provide your relevant funding details

National Disability Insurance Scheme (NDIS) NDIS Number: _____

Self Managed Plan Managed

Plan Manager Contact Details: _____

My Aged Care (MAC) My Aged Care Number: _____

Do you have a Chronic Disease Management Program (CDMP) Yes No

Do you have a Mental Health Care Package (MHCP) Yes No

Do you have someone who supports you and acts as a Primary Support Person? Yes No

If yes, this person is my: Spouse/Partner Child Other family member Paid Carer

Living Arrangements: I live alone I live with family member(s) I live with others

Accommodation Setting: Private residence (owned) Private rental Public rental

Aged Care Home Independant/Retirement Village

Other : _____

PRIMARY SUPPORT / CARER DETAILS

Full Name: _____ Date of Birth: / /

Gender Identity: Male Female Non-Binary Other: _____

Address: _____

Mobile/Phone Number: _____ Email Address: _____

Country of Birth: _____ Cultural Identity/Ancestry: _____

Language Spoken: _____ Interpreter Required? Yes No

Do you identify as: Aboriginal Torres Strait Islander Neither I prefer not to say

Relationship to the person for whom I care is: Spouse/Partner Son/Daughter Parent

Friend/Neighbour Son-in-law/Daughter-in-law Other relative

Do you live with the person for whom you provide care? Yes No

