



**Arafmi Mental Health Carers and Friends Association  
RECREATION PROGRAM  
APPLICATION FORM**

(To be completed by the prospective participant or their carers)

**Personal Details of the Prospective Participant:**

**Surname:** ..... **Given Names:** .....

**Home Address:** .....

**Post code:** ..... **Telephone no:** .....

How did you hear about the Arafmi Recreation Program? .....

**Date of Birth:** ...../...../..... **Age:**.....

**Next of Kin:**.....**Relationship:**.....

**Contact Address:** .....

**Post code:**..... **Telephone:**.....

**Person to be contacted in case of emergency:**.....

**Telephone:**.....

Does the prospective participant have any **special dietary considerations** or needs?

.....

**Medical Details:**

**Psychiatric Diagnosis:** .....

Does the prospective participant have any **physical health problems** which  
Require attention e.g. Diabetes, Epilepsy, etc?

NO

YES

.....

**Current Medication:**

<u>Name:</u>	<u>Dosage:</u>	<u>Frequency:</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....

Does the applicant manage their own medications? NO  YES

Name of the treating Psychiatrist, GP or current treating health professional:

.....

Telephone:.....

General Practitioner:.....

Telephone:.....

**Please note that all bookings for events are conditional until a health report is received 1 week prior to the commencement of the activity.**

Name:.....

Signature:.....Date:.....

Please forward this completed application to :

Arafmi Mental Health Carers and Friends Association  
 Recreation Program  
 182 Lord Street  
 Perth 6000

Ph: (08) 9427 7100  
 Fax: (08) 942707119

**Office Use Only:**

Applicant and/or carer interview: NO  YES

Holiday Booked: NO  YES

Health Professional's recommendation received NO  YES

Holiday confirmed with participant NO  YES

**ALL INFORMATION PROVIDED IN THIS DOCUMENT WILL BE TREATED AS CONFIDENTIAL.**



Has there been any history of: (please include details)?

Violence.....

.....

Attempted Suicide/Self Harm.....

.....

Alcohol Substance Abuse.....

.....

In your opinion, is the applicant currently in need of acute psychiatric Intervention?

NO  YES

Signed:.....Date:.....

Name:.....Profession.....

Please note:

On completion of this form the health professional is to send it to

**Arafmi Mental Health Carers and Friends Association**

**182 Lord Street**

**Perth 6000**

**Ph: (08) 9427 7100**

**Fax: (08) 9427 7119**

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**This section will be returned to the applicant, on receipt of the completed application/assessment forms, at Arafmi**

**Receipt of Recreation Program Application/Assessment Forms**

**Applicants Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Post Code:** \_\_\_\_\_

**Date received at Arafmi:** \_\_\_\_\_ **Entered on Database:** \_\_\_\_\_

**Please Note: The Applicant will be contacted by the Recreation Officer for a suitable program placement.**