Request for Admission to Ngala WEB-02

Ngala is a private hospital and requires the patient's medical practitioner to authorise each admission. Please complete details of adult/parent and child/children for admission. If you are not the medical practitioner please print the completed form, insert your details in the appropriate section and return to family for their doctor to complete and sign.

ALL REQUEST FOR ADMISSION MUST BE COMPLETED AND SIGNED BY A MEDICAL PRACTITIONER

Doctors Name:			
Address 1 (practice):			
Address 2 (street):			
Post Code:		State:	WA
Email:			
Phone:			
Provider Number:			

FAMILY MEMBERS FOR ADMISSION

	Full Name	Date of Birth
Primary Caregiver:		
Reason for Admission:		
Accompanying Partner:		
Reason for Admission:		
Child in Focus:		
Reason for Admission:		
Child in Focus:		
Reason for Admission:		
Child in Focus:		
Reason for Admission:		

Doctor's Signature

Date

On completion of this form please forward for the attention of Ngala 's Intake Nurse either by mail : Ngala, 9,George Street Kensington Perth WA 6151, fax 08 9368 9398 or email to Intake@ngala.com.au.

Ngala
Parenting with Confidence

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Your patient may have already discussed the most appropriate service with our Parenting Line staff or Intake Nurse, the criteria for admission options are below. If you wish to discuss further please call the Ngala Intake Officer on 9368 9364.

Service Preference:

☐	Extended stay admission	Is experiencing moderate to high levels of psychosocial distress some risk factors are present. Will be able to meet the needs of their child with sustained support (up to 4 day/night admission).
☐	2 Day stay admission	Is experiencing low to moderate levels of psychosocial distress. Will be able to meet the needs of their child with a short period of up to two days support.
☐	Day stay admission	Is experiencing low levels of psychosocial distress. Will be able to meet the needs of their child with a brief period (6 hours) of support.

PARENT TO BE ADMITTED AS PATIENT

Surname:			
Given Name:			
Preferred Name (if any):			
Gender:	☐ Male	☐ Female	☐ Diverse
Date of Birth:			
Aboriginal or Torres Strait Islander:	☐ Yes	☐ No	
Relationship to Child:			
Contact Number (mobile preferred):			
Address:			
Post Code:		State:	WA
Email:			
Does the patient have private health cover:	☐ Yes	☐ No	
Name of Health Fund:			

Reason for Admission:

- ☐ Adjustment to parenting
- ☐ Family health/social issues
- ☐ Parental stress/fatigue
- ☐ Anxiety
- ☐ Postnatal depression diagnosed
- ☐ Symptoms of depression or other emotional state
- ☐ Other

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Patient Details:

	Yes	No	If yes insert details
Past or current mental health issues	☐	☐	
Past or current drug & alcohol misuse	☐	☐	
Identified current domestic violence	☐	☐	If yes, is there a Violence Restraining Order in place ☐ Yes ☐ No
Current medications	☐	☐	
Any allergies	☐	☐	
Disability	☐	☐	
Special dietary requirements	☐	☐	
An EPDS score completed in the last 7 days	☐	☐	If yes insert score
A current risk of suicide/self-harm	☐	☐	

CHILD TO BE ADMITTED AS PATIENT:

Surname:			
Given Name:			
Gender:	☐ Male	☐ Female	☐ Unknown
Date of Birth:			
Aboriginal or Torres Strait Islander:	☐ Yes	☐ No	
Place in Family:			

Reason for Admission:

☐ Feeding/Nutrition

☐ Sleep/Settling

Please discuss with your patient: Ngala's policy states babies less than 6 months of age are to sleep on their back. Cuddlies and soft toys are not to be used in cots. Refer to WA Department of Health policy and Red Nose recommendations.

☐ Child Development/Behaviour

☐ Colic or Reflux

☐ Other

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Patient Details:

	Yes	No	If yes insert details
Any medical conditions	☐	☐	If yes insert details and management
Any current medications	☐	☐	
Allergies	☐	☐	
Disability	☐	☐	
Feeding issues	☐	☐	
Special dietary requirements	☐	☐	
Feeding type	☐ Breast	☐ Formula	☐ Solids
Is the child's immunisation up to date	☐	☐	If no insert details

SECOND CHILD TO BE ADMITTED AS PATIENT:

Surname:			
Given Name:			
Gender:	☐ Male	☐ Female	☐ Unknown
Date of Birth:			
Aboriginal or Torres Strait Islander:	☐ Yes	☐ No	
Place in Family:			

Reason for Admission:

☐ Feeding/Nutrition

☐ Sleep/Settling

Please discuss with your patient: Ngala's policy states babies less than 6 months of age are to sleep on their back. Cuddlies and soft toys are not to be used in cots. Refer to WA Department of Health policy and Red Nose recommendations.

☐ Child Development/Behaviour

☐ Colic or Reflux

☐ Other

Ngala
Parenting with Confidence

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Patient Details:

	Yes	No	If yes insert details
Any medical conditions	☐	☐	If yes insert details and management
Any current medications	☐	☐	
Allergies	☐	☐	
Disability	☐	☐	
Feeding issues	☐	☐	
Special dietary requirements	☐	☐	
Feeding type	☐ Breast	☐ Formula	☐ Solids
Is the child's immunisation up to date	☐	☐	If no insert details

THIRD CHILD TO BE ADMITTED AS PATIENT:

Surname:			
Given Name:			
Gender:	☐ Male	☐ Female	☐ Unknown
Date of Birth:			
Aboriginal or Torres Strait Islander:	☐ Yes	☐ No	
Place in Family:			

Reason for Admission:

☐ Feeding/Nutrition

☐ Sleep/Settling

Please discuss with your patient: Ngala's policy states babies less than 6 months of age are to sleep on their back. Cuddlies and soft toys are not to be used in cots. Refer to WA Department of Health policy and Red Nose recommendations.

☐ Child Development/Behaviour

☐ Colic or Reflux

☐ Other

Patient Details:

	Yes	No	If yes insert details
Any medical conditions	☐	☐	If yes insert details and management
Any current medications	☐	☐	
Allergies	☐	☐	
Disability	☐	☐	
Feeding issues	☐	☐	
Special dietary requirements	☐	☐	
Feeding type	☐ Breast	☐ Formula	☐ Solids
Is the child's immunisation up to date	☐	☐	If no insert details

OTHER SERVICES OR PROFESSIONAL WORKING WITH THE FAMILY/PATIENTS

		If ticked details
☐	Paediatrician	
☐	Child Health and Nurse	
☐	Child Protection & Family Support	
☐	Child Development Service	
☐	Drug and Alcohol Worker	
☐	Psychiatrist, Psychologist or Mental Health Service	

ADULT PATIENT'S PARTNER OR OTHER EMERGENCY CONTACT (partner or support persons are encouraged to attend)

Surname:			
Given Name:			
Gender:	☐ Male	☐ Female	☐ Diverse
Aboriginal or Torres Strait Islander:	☐ Yes	☐ No	
Contact Number (mobile preferred):			

	Yes	No	
Will partner/support person be attending service?	☐	☐	
Does this partner have any current health or drug abuse issues?	☐	☐	(if yes insert details)

REFERRING AGENCY/PROFESSIONALS (if not medical practitioner)

All admissions require completed medical practitioner request and signature please print completed form for doctor to insert details.

Name:	
Position/Occupation:	
Name of Organisation:	
Contact Phone:	
Email:	
	Email to Intake@ngala.com.au

Signature _____ Date _____

If Child Protection & Family Support all information below must be provided

	Yes	No	
Is the child/children currently in the care of the parents?	☐	☐	(if no details)
Is the client currently using drugs/alcohol?	☐	☐	**Please provide details**
Are there any factors that would inhibit the completion of the Ngala program?	☐	☐	**If yes, provide details**

Detail caseworker expectations for the family care during Ngala admission.

(insert in 250 words and attach or email document to Intake@ngala.com.au)

Please email latest Signs of Safety minutes, Harm Statements and Safety Goals and any available mental health or psychological reports to Intake@ngala.com.au.

DCPFS Case Manager Details:

Name:	
Phone:	
Email:	
Location	

Signature _____ Date _____