NEW CLIENT REGISTRATION FORM

MAKING STRIDES

WELCOME TO MAKING STRIDES!

Before Attending Making Strides please check the terms and conditions found ay www.makingstrides.com.au. Use the checklist below to ensure you have completed and returned all relevant documentation before submitting your application pack.

1. New Client Registration Form;
2. Service Agreement;
3. Medical Clearance Form; and
4. Bone Density Report (results to be forwarded to Making Strides with New Client Application pack)

**If available please provide a copy of your hospital discharge summary or recent medical history.

TO SUBMIT:

Please email your completed application pack to info@makingstrides.com.au OR drop it into Making Stride in person.

NEW CLIENT REGISTRATION FORM

PROVIDER DETAILS

Making Strides Pty Ltd ACN 165 965 917
2/7 Dover Drive, Burleigh Heads, QLD

PARTICIPANT DETAILS

Date of Application: ______________________________

Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Emergency Contact details
Name: ______________________________

Contact number: ______________________________

Email: ______________________________

Relationship: ______________________________

How did you hear about Making Strides?

- ☐ Social Media
- ☐ Friend/Family Member
- ☐ Professional Referral
- ☐ Internet Search

Program Duration/ Type:

- ☐ Local Client/ Ongoing
- ☐ Activity Based Therapy
- ☐ Visiting Client/ Occasional
- ☐ Adaptive Gym Program

MAKING STRIDES

DETAILS OF CONDITION

- [ ] Spinal Cord Injury (go to section A)
- [ ] TBI / ABI (go to section C)
- [ ] Cerebral Palsy (go to section E)
- [ ] Multiple Sclerosis (go to section B)
- [ ] Stroke (go to section D)
- [ ] Other (go to section F)

Section A:

Level of Spinal Cord Injury: ______________________________

ASIA Score: ______________________________ Complete/Incomplete: ______________________________

How did you acquire your Spinal Cord injury? ______________________________

Date of injury/onset? ______________________________

Details of any rods/plates in Spinal Column: ______________________________

Which hospital did you attend? _______________ Date of discharge: _______________

Treating Doctor / Neurologist: ______________________________

Date of last specialist consultation/outpatient review: ______________________________

Do you experience Autonomic Dysreflexia? ______________________________

Section B:

Type of Multiple sclerosis: ______________________________

Date of Diagnosis: ______________________________

Current physical function: ______________________________

Treating Doctor / Neurologist: ______________________________

Date of last specialist consultation/outpatient review: ______________________________

Section C:

Area of Brain affected: ______________________________

Date of injury and how it occurred: ______________________________

Current physical function: ______________________________

Current cognitive function: ______________________________

Any known mood disorders: ______________________________

Do you suffer from any form of memory loss? ______________________________

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Section D:

Date of Stroke: _______________

Cause/type of Stroke: ______________________________

Current physical function: ______________________________

Current cognitive function: ______________________________

Any known mood disorders: ______________________________

Do you suffer from any form of memory loss: ______________________________

Section E:
Type of Cerebral Palsy: ___
Current physical function: ___
Current cognitive function: ___
List any surgeries related to your condition: ___

Section F:
Please give as much detail about your condition as possible: ___

MEDICAL HISTORY

Please indicate if any of the following apply to you

- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Recent Surgeries
- ☐ Type I Diabetes
- ☐ Lung Disease/Disorders
- ☐ Heart Disorder (AF/VF)
- ☐ Other:
- ☐ Deep Vein Thrombosis
- ☐ Current/Previous Pressure Sores
- ☐ Previous Other Major injuries
- ☐ Dizzy/fainting spells
- ☐ Type II Diabetes
- ☐ Pregnant or trying to fall pregnant
- ☐ Epilepsy
- ☐ Skin Conditions
- ☐ Fractures
- ☐ Muscular Conditions
- ☐ Asthma
- ☐ Heart Disease
- ☐ Smoke Cigarettes

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

Please list any medications you are currently taking (please include the **name, dose,** and **function**)

Are you currently taking part in any forms of rehabilitation or exercise? If yes, please detail.

FUNCTIONAL ABILITY

- [ ] Power Wheelchair with chin control
- [ ] Power wheelchair with hand control
- [ ] Manual Wheelchair
- [ ] Walking Frame, Crutches or Canes
- [ ] AFO, KAFO or another orthotic
- [ ] Other: ____________________
- [ ] Mobility Scooter

Please provide details for the following:

What assistance do you require for transferring?

Describe your upper limb function

Describe your core/torso function

Describe your lower limb function

Do you experience muscle spasm/tone? If yes, please provide details

Do you experience nerve pain? If yes, please provide details of where and how this is managed.

List any previous or current musculoskeletal injuries

Please list any other issues, complications or notes you think Making Strides need to be made aware of.

GOALS

Short Term Goals: ____________________

Long Term Goals: ____________________

Is there any other services you wish to explore while attending Making Strides? (e.g., Massage Therapy, Orthosis Information, Dietician, Nursing Solutions etc.) ____________________

MEDICAL CLEARANCE

(To be filled out by your medical professional)

☐ Activity Based Therapy: An individually designed exercise program aimed to improve functional independence and mobility through skill acquisition. The program involves repetitive, task specific and dynamic activities all performed out of the wheelchair. Delivered one-on-one with an Accredited Exercise Physiologist.

☐ Strength & Conditioning: Delivered one-on-one, this is an individualised program based on progressive resistance, range of motion and cardiovascular training aimed at improving overall health, strength, fitness, and endurance.

☐ FES: Functional Electrical Stimulation (FES) is a therapy utilising an electrical current to stimulate peripheral nerves, eliciting a muscle contraction and functional motor patterning.

☐ Load Bearing Activity: Activities such as crawling, standing, and kneeling may be included, with the necessary support required for the individual to perform safely.

☐ Independent wheelchair-based Strength & Conditioning: Independent use of accessible gym equipment, following a program designed by an Exercise Physiologist.

Your patient will undergo an initial evaluation by Making Strides to ascertain whether Making Strides' services are appropriate to their individual needs. The assessment includes manual muscle testing, motor development scale and contraindications evaluation.

To determine if your patient is eligible to participate at Making Strides we require you to please provide:

1. Any general comments / recommendations in relation to your patient;
2. Your medical clearance for your patient to participate at Making Strides; and
3. A bone density report and your interpretation of the report. **(Please note we require T-score results)**

Please note that locomotor training and load bearing activity will involve partial and full bodyweight load bearing activities unless you stipulate otherwise in the comments section below.

Please complete the approval below, for the patient to bring to their initial assessment. If you wish to discuss the program or any concerns regarding your patient, please to not hesitate to contact us on 07 5520 0036 or info@makingstrides.com.au.

Kind regards,
Making Strides

MEDICAL CLEARANCE

(To be filled out by your medical professional)

I hereby approve participation in the Making Strides program as outlined above.

Patient's Name: ______________________________

Patient's Address: ______________________________

Comments and Recommendations:

Provider's Name: ______________________________

Provider's Number: ______________________________

Provider's Signature: ____________________ Date: ____________________

Please place Doctor stamp here

FEE SCHEDULE

Service	Fee	Provider
Exercise Physiology	$166 per hour	Exercise Physiologist
Small Group Training	$85 per hour	Exercise Physiologist
Hydrotherapy	$250 per session	Exercise Physiologist
FES Therapy	$125 per session	Exercise Physiologist
Initial Evaluation (Plus 1 hour data entry)	$166 per hour	Exercise Physiologist
Community Access Support	$54.30	Therapy / Disability Support Worker
Massage Therapy	$120 per hour	Massage Therapist
Report preparation	$166 per hour	Exercise Physiologist
Accessible Gym	$40 / week	Independent
Accessible Gym (existing client training 2 sessions / week)	$20 / week	Independent

Date Effective: January 1, 2022

CANCELATION POLICY

Making Strides requires a minimum 24 hours' notice for cancellations. In the event of late notice without due cause; Making Strides reserves the right to charge a cancellation fee equivalent to the cost of the service booking.

A three strike policy will apply for both Exercise Physiology Sessions and attendance of the Accessible Gym. If three Exercise Physiology sessions are missed (without approved reason) within a one-month period, your recurrence will be removed. If three Accessible Gym bookings are missed or more than 15- minutes late, then you will be moved to a wait-list. Extenuating circumstances will be considered on a case-by-case basis.
If the Participant wishes to give the Provider feedback or make a complaint, the Participant can contact the Provider at info@makingstrides.com.au or 07 5520 0036.

If the Participant is an NDIS participant and is not satisfied, the Participant can contact the National Disability Insurance Agency by calling 1800 800 110, visiting one of their offices in person, or visiting ndis.gov.au for further information.

SERVICE AGREEMENT

BILLING DETAILS

Please indicate who will be responsible for payment of the account

☐ Individual – Self Pay

☐ NDIS

☐ Medicare Rebate - EPHC/Team Care Arrangement iCare/Lifetime Care

☐ Workcover

☐ TAC

☐ Insurance Agency - Other

☐ Disability Funding Service Provider - Other

Name of funding provider if not listed NDIS Participant

____

Number (if applicable)

____

Case Manager/Coordinator/Plan Manager details

____

Email address for invoices

____

SERVICE AGREEMENT

Upon signature of the Participant and submission to the Provider, this Client Registration Form shall evidence the Participant's intention to enter a legal relationship with the Provider.

The terms of this Client Registration Form and the Service Agreement shall form a binding agreement on the Participant and the Provider upon countersignature by an authorised representative of the Provider, unless this Client Registration Form is rejected by the Provider.

The Service Agreement can be found here: www.makingstrides.com

Signature of [participant/participant's representative]

Name of [participant/participant's representative]

Date: ______________________

Signature of authorised person from provider

Name of authorised person from provider

Date: ______________________