



The Police Treatment Centres

Application for Admission - INPATIENT

PART 1 - To be completed by the applicant (Please print in **BLACK ink):**

| | | | |
|--|--|---|--|
| Surname: Forenames: (Preferred Name:) | | Office Use Only | |
| Any previous names: (e.g. change of name on marriage): Surname: Forenames: | | Date received | |
| | | Donation check | |
| Date of birth: Gender (please circle): <div style="text-align: right;">M / F</div> | | Date entered on system | |
| | | Date @ Nurse | |
| Current police force, or if retired, previous force: Date joined: Collar Number: Date retired: Police Pension No: | | Date @ Physio | |
| | | 1 st allocated | |
| | | 2 nd allocated | |
| | | 3 rd allocated | |
| Address: Post Code: | | Contact details: Home telephone: Mobile telephone: Other telephone (state): Email 1: Email 2: | |
| Next of Kin - Name & relationship: | | Next of Kin - Contact Details: | |
| Admission Preference: (please tick): St Andrews, Harrogate <input type="checkbox"/> : Castlebrae, Auchterarder <input type="checkbox"/> : EITHER <input type="checkbox"/> : NOTE: By selecting EITHER you may receive treatment sooner than by selecting a named Centre. | | | |
| Any specific accommodation requirements: (e.g. more than 6 feet tall; Hearing impaired – re fire alarms; Weight etc): | | | |
| Any special dietary requirements: (e.g. allergies or intolerances): | | | |
| Dates to Avoid: (please include all leave/holiday, Court, or other known commitments for the next twelve weeks): | | | |
| Can you attend at short notice? (e.g. one week's notice) YES / NO | | Do you intend to stay at the Centre over the weekend? (If more than one week admission; or retired officer) YES / NO | |
| Legal Claims: Have you any legal claims pending, or contemplated (current treatment circumstances): YES / NO | | | |

PART 2 - To be completed by the applicant - Please indicate which of the following applies to you:

At work On recuperative/
restricted duties On sick leave Other (specify)

Describe how your condition happened: (e.g. accident/event at work/post-operative/long-term illness):
.....
.....

What treatment have you already had for this condition: (e.g. medication/operation/physiotherapy/osteopath/chiropractor):
.....
.....

Is your condition improving/getting worse/staying the same/other? (please describe):
.....
.....

What benefit do you hope to gain from your admission to a Treatment Centre?:
.....
.....

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| Have you attended the PTC before?: YES / NO | If YES , when was your most recent attendance? |
|--|--|

If **YES**, was it with the same or similar condition / a different condition to be the one you have now? :
.....

If the same condition, what was the outcome? (e.g. Worse / no change / short term improvement / long term improvement):
.....

If necessary: Companion (spouse/partner etc.):
Please complete the 'Application to be Accompanied by a Companion' form and attached that to this application.

Companions Full Name:
.....

Personal Information: *Personal information which you supply to us may be used in a number of different ways, for example: To make admission and clinical decisions; for audit and statistical analysis; for fraud prevention.*

I understand that all personal information on this form will be confidential to the professional and administrative staff of the PTC and no personal information or clinical reports will be shared without my express consent unless required to do so by law.

I agree to include in any claim for damages pursued by me against the third party in respect of the accident resulting in my injury such sums as may be specified by The Police Treatment Centres as the costs of its provision of my treatment

In order to provide the best possible levels of service, updates or other information I agree to the PTC contacting me using the details I have provided.

I have supplied my most recent pay slip and one from at least six months previously validating my regular donation to the PTC.

Signature: **Date:**

PART 3 - HIGHLY CONFIDENTIAL - to be completed by: Force Medical Officer or Occupational Health Nurse or Physiotherapist or G.P.

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|-------------------|---------------------------|
| Diagnosis: | Date of Diagnosis: |
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|------------------------------|
| Duration of symptoms: |
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| Underlying conditions/relevant medical history: |
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| Ongoing investigation/treatment: |
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| Nature/date of operations/scans/x-rays <i>(please list):</i> <i>(if available, please bring with you any treatment protocols or guidelines; X-rays / MRI scans/ reports that may be of benefit to our physiotherapists during your admission e.g. ACL rehab detail; weight bearing details in the case of lower limb fracture, shoulder injury; other rehab guidelines);</i> | Discharge date <i>(if applicable):</i> |
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|--|------------------------------|-----------------------------|--------------------------------------|
| Stress/psychological/psychiatric issue? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |
| Limited Mobility? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |
| Is Nursing assistance required with the 'Activities of Daily Living'? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |
| Does companion need to attend? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |
| Medication/Infections/Allergies? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |
| Is physiotherapy required? | YES <input type="checkbox"/> | NO <input type="checkbox"/> | If YES please complete PART 4 |

PART 4 - Stress/psychological/etc:

Please state fully any treatment or risk factors (i.e. prescribed drugs, alcohol abuse, self-harm risk). **Please note:** there are **NO** psychiatric or counselling facilities at either Centre, therefore they are unsuitable for acute psychiatric illness.

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| Is the applicant receiving, or has the applicant previously received, counselling/psychiatric support? |
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| |

Support: *please expand on the nature of support required by the applicant:*

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.....
.....

Medication/allergies/infections:

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.....
.....

Mobility and Access: *Can the applicant climb stairs / walk unaided? Please give distance. Is the applicant a wheelchair user? Full / partial or non-weight bearing? Expand fully on assistance level if needed on a daily basis and especially if at risk from falling:*

.....
.....

PART 5 - Signature of: Force Medical Officer or Occupational Health Nurse or Physiotherapist or GP.

Certified by (signature): Print name: Date:

Address:

..... Post Code:

Tel No: Email:

PART 6 - To be completed by Force representative / Police Federation Office :

The applicant is (or was, in the case of a retired officer) a regular donor to The Police Treatment Centres.

Please note: *Treatment will not be provided free of charge if the applicant does not, or if retired did not, make the payroll giving donation to support the Charity. If you are unable to verify the applicant is (or was, in the case of a retired officer) a regular donor to the Charity, the applicant **MUST** provide two payslips, including the most recent and the other at least six months earlier, to the physiotherapy department otherwise treatment will not commence.*

Certified by (signature): Print name: Date:

Job Title: Department:

Tel No: Email:

Any other relevant information:

.....

Once all parts have been completed, please post this application form to:

Admissions

The Police Treatment Centres
St Andrews
Harlow Moor Road
Harrogate
North Yorkshire
HG2 0AD

Contact details:

Tel: 01423 504448
Fax: 01423 527543

Email: enquiries@thepolicetreatmentcentres.org
Web: www.thepolicetreatmentcentres.org

Application Checklist:

Please ensure that all items on the checklist have been enclosed or completed.

Failure to do so may delay consideration of your application form and allocation of an admission date if, as a result, further enquiries have to be made about your application.

| TICK | |
|------|---|
| | PARTS 1 AND 2: To be fully completed by you - the applicant |
| | PARTS 3, 4 AND 5: Signature of: Force Medical Officer <u>or</u> Occupational Health Nurse <u>or</u> Physiotherapist <u>or</u> G.P |
| | PART 6: Signature of designated Force representative e.g. Occupational Health OR Police Federation Office |
| | Pay Slips: Two copies of your pay slips showing PTC donations if applicable (most recent and one from between six and 12 months previously). |
| | If your personal circumstances require essential daily support to undertake the activities of daily living e.g. getting dressed: A completed Companion Application Form (if applicable). |