neuroMoves
Spinal Cord Injuries Australia

INTAKE FORMS

These forms can be returned in the following ways:

- Scan & Email: info@scia.org.au
- Fax: 02 7202 0944
- Post: PO Box 397, Matraville NSW 2036
- Dropping a hard copy to your local NeuroMoves site

Please note that intake forms are required prior to attending your initial assessment at NeuroMoves

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Client Information

Client Details		
First Name:	Surname:	
Preferred Name:	Date of Birth:	Age:
Phone:	Mobile:	
Address:		
Gender: ☐ Male ☐ Female ☐ Other/Detail: _____ ☐ Prefer not to say Preferred pronoun: ☐ he/☐ him; ☐ she/☐ her; ☐ they/☐ them		
Email:	Preferred contact method: ☐ Phone ☐ Email ☐ Either	
Are you currently working: Yes No	Occupation (Adult):	
Are you currently attending school: Yes No	School Year (Child):	
What language do you speak at home? English, or Other:_____. Is a translator required: Yes No *Please note that if a translator is required, it is the client's responsibility to organise this.* Do you identify as Aboriginal or Torres Strait Islander? Yes No What is your cultural background? _____		

Next of Kin (Parent/Guardian for children) / Emergency Contact Details	
First Name:	Surname:
Relationship:	Phone/Mobile:
Email:	Set this person as the primary contact ☐ Yes ☐ No

Details of Condition		
Type of condition:	☐ Spinal Cord Injury SCI Level: _____ ASIA Level: ☐ A ☐ B ☐ C ☐ D ☐ N/A or unknown	
	☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Traumatic Brain Injury ☐ Stroke ☐ Spina Bifida ☐ Neuropathy ☐ Other (detail below): _____	
How was injury / condition acquired?		
Treating Hospital:		Date of discharge:
Specialist Name:		
Community GP name & address:		Phone:

Comment briefly on the following to help us prepare for your initial assessment	
Mobility: ☐ Walk independently ☐ Use a walking aid ☐ Manual wheelchair ☐ Power wheelchair	
Are you currently undertaking any regular exercise? Yes No Please detail:_____	
Please detail any communication barriers (ie: nonverbal, difficulty understanding/ difficulty in speaking):	
Please detail any challenging behaviours (ie: aggression, frustration, impulsiveness, problems with memory and attention):	

Session Payment

1. Are you funded through NDIS: Yes No
If yes, your therapist will help you and/or your support coordinator (if applicable) to complete an NDIS service agreement following your initial assessment.

2. Are you funded by another third party (ie: state insurance body, aged care package): Yes No
If yes, your therapist will help you and/or your third party contact (if applicable) to complete a third-party billing details form following your initial assessment.
Third party name & contact person:_____

3. Are you self-funded and planning to pay for sessions privately? Yes No
If yes, your therapist will ask you to complete a direct debit payment form following your initial assessment.
You may be eligible for a NeuroMoves Fee subsidy – ask your therapist about this

Additional Information

How did you hear about us? *Tick all that apply*
☐ Current NeuroMoves client ☐ Referred by a health professional ☐ Online search
☐ NDIS Support Coordinator ☐ Social Media ☐ Other/Detail: _____

Name/ details of person who referred you (if known):

SCIA Membership:	I would like to become a free member of SCIA Yes No Already a member
Preferred location:	☐ Hove, Adelaide ☐ Angle Park, Adelaide ☐ Brisbane ☐ Melbourne ☐ Perth ☐ Canberra ☐ Lismore ☐ Clyde, Sydney ☐ Liverpool, Sydney ☐ Menai, Sydney ☐ Penrith, Sydney ☐ St Peters, Sydney ☐ Ferguson Lodge, Sydney ☐ Other - please specify _____
Session type you are interested in: *Tick all that apply*	☐ Locomotor Training ☐ Activity Based Therapy ☐ Strength & Conditioning ☐ Functional Electrical Stimulation ☐ Gym ☐ Group ☐ Hydrotherapy ☐ Home visits ☐ Unsure

Personal information collected on this form will be retained and used for the purpose of Spinal Cord Injuries Australia (SCIA) providing supports and services. Without this information SCIA may be unable to provide supports and services to you. SCIA might disclose your personal information to a third party such as a Social Worker or other health professional, an employer, an agency or service provider or the relevant Federal or State Government Department as required under our funding agreements. Some of these parties may be located overseas. We may collect personal information from a third party such as your carer, trustee or authorised representative. If you give us personal information about another person, you must ensure they are provided with a copy of this Privacy Notice. Lodging this form with SCIA indicates your consent for SCIA to collect your personal information. Our Privacy Policy contains further details, including accessing personal information we hold about you and making a privacy complaint. You can view our Privacy Policy on our website at: http://scia.org.au/privacy-policy or obtain a copy by phoning 1800 819 775.

Schedule 3: NeuroMoves Terms & Conditions

NeuroMoves (NM) is a service provided by Spinal Cord Injuries Australia (SCIA).

1. **Information:** A welcome pack will be provided to you with more information about NM. Feel free to discuss this with a NM therapist and more information can be found on the SCIA website.
2. **Payment:** Prior to your first session at NeuroMoves, you will be required to complete an SCIA service agreement that details your responsibilities & SCIA's responsibilities. A copy of the NM fee schedule can be found on our website https://scia.org.au/neuromoves-how-to-apply/.
3. **Supervision and guidance:** At each of your visits to a NM site, our staff or authorised representatives, will provide you with supervision and guidance for your Exercise Program. You will not be required to participate in any activity or exercise as part of the Exercise Program that you do not consider as appropriate and acceptable to you. Prior to, or at any time during, any activity or exercise, you may advise NM staff that you do not wish to take part in an activity or exercise. Your participation in an activity or exercise will confirm that it is appropriate and acceptable to you.
4. **Medical advice:** You agree to confirm with a medical practitioner that the activity and exercise offered by NM is suitable for you, and to arrange for your medical practitioner to complete our Medical Clearance Form. The Exercise Program does not constitute medical advice, diagnosis or treatment. You are responsible for obtaining all necessary medical advice in relation to NM and your participation in the program.
5. **NeuroMoves sessions:** Whilst engaging in an Exercise Program you will be responsible for:
    a. Complying with the reasonable directions of NM staff;
    b. Immediately advising NM staff of any change to your medical condition or overall health e.g. autonomic dysreflexia, medication change, skin breakdowns, blisters or pressure areas; as a result of the Exercise Program or any other medical condition that may affect your participation in the Exercise Program.
    c. Advising NM staff at any time if you do not wish to take part in any activity or exercise, or if you feel uncomfortable for any reason; and
    d. If required, providing your own personal care (such as toileting, washing, dressing and feeding)
6. **Risks:** Participation in the NM Exercise program carries with it inherent risks for a person with a neurological condition or other impairment. These inherent risks include general and specific risks of harm inherent in participating in exercise therapy. These risks range from minor injury such as scratches, bruising, or muscle strains; to major injury such as bone fracture, joint injury, heart attack or concussion; to catastrophic injury such as further paralysis or death. You acknowledge that as an individual with a neurological condition, you may be at increased risk of osteopenia or osteoporosis, which places you at increased risk of bone fractures.
   You understand and acknowledge the inherent risks of participation in the NM Exercise Program and agree:
    a. that participation in NM therapy and exercise is at your own risk
    b. that certain risks cannot be avoided despite the exercise of reasonable care and skill
    c. to assume and accept all risks resulting from or attached to such participation; and
    d. to give release and indemnity relating to the exercise program, NM staff and our facilities.
7. **Release and indemnity**:
    a. To the full extent permitted by law; you release SCIA, its staff and agents from all liability arising out of any duty of care to you in connection with these terms and conditions or your

participation in the NM Program; and you agree not to make any claim against SCIA, its staff and agents relying upon a duty of care in connection with the NM Program.

b. To the full extent permitted by law; you indemnify SCIA against all liability, claims, loss, costs and expenses (including legal fees, costs and disbursements) arising from or incurred in connection with this agreement or your participation in the NM Program.
c. Each indemnity in this Agreement is a continuing obligation, separate and independent from other obligations of the parties, and survives termination, completion or expiration of this Agreement.
d. If at any time a provision of this Agreement is or becomes illegal, invalid or unenforceable; that part of the Agreement shall be severable and no longer form part of the Agreement; however, the Agreement shall otherwise continue in full force and effect.

8. **Termination:** For any reason, either you or SCIA may terminate this agreement upon written notice to the other party. NM reserves the right to not allow you to participate in NM at its absolute discretion.
9. **Cancellation Policy:**
   a. If you are unable to attend a session, you must provide NM with 3 business days' notice of your cancellation. If you do so, you will not be charged for the session and NM will then work with you to reschedule the session.
   b. If you fail to notify NM 3 business days before your scheduled appointment, NM will charge a fee for the cancellation which is 100% of the cost of a session.
   c. If NM are required to cancel your session, NM will give you as much notice as possible, and you will not be charged for this session
10. **Specific Consent:** The below points 10.1 – 10.4 are completely optional. You should read the below points carefully and by ticking the boxes you are agreeing to the statements provided:

10.1 You consent to clinical placement students being involved within your Exercise Program session.	☐
10.2 You consent to NeuroMoves using health and physical assessment data collected of You for research purposes. Your data may be used without identification for external purposes including (but not limited to) scientific journal articles, conference posters or oral presentations.	☐
10.3 You consent to NeuroMoves using any photographs or videos of you taken by SCIA or its authorised representatives during any Visit, for **internal purposes** including (but not limited to) the training of staff.	☐
10.4 You consent to NeuroMoves using any photos/videos of You taken by NeuroMoves or its authorised representatives during any Visit, for **external purposes** including (but not limited to) publication on promotional materials on the SCIA website & social media.	☐

By signing below, you acknowledge and warrant that you have read and understood the terms and conditions listed above and provide your informed consent to participate in the NeuroMoves program:

Name of Participant _____ Signature of Participant _____

Date _____

Name of Parent/Guardian (if applicable) _____ Signature of Parent/Guardian (if applicable) _____

Date _____

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Medical Clearance

Dear Doctor,

Your patient would like to participate in exercise therapy with a Physiotherapist and/or Exercise Physiologist at NeuroMoves. Given the complex health conditions we see at NeuroMoves and the intensity and type of exercise therapy we may provide, we request a medical clearance every 24 months, or earlier due to a major change in medical status. Such clearance assists us in ensuring that we provide the most effective and safe modalities of therapy to help our clients achieve their goals.

Patient Details	
First Name:	Surname:
Date of Birth:	
Address:	

Please tick <u>all</u> the following modalities in Part 1 and 2, that you provide clearance for your patient to participate in

Part 1: Load Bearing Exercises	
Load Bearing: ☐ Yes ☐ No	Exercises that can involve load bearing to the limbs. Such exercises may be performed out of the wheelchair. Involving but not limited to: ○ Cardiovascular exercises (e.g.: arm ergo, boxing) ○ Body Weight Supported Treadmill Training ○ Load bearing (partial and full) in different positions including standing, kneeling, crawling ○ Repetitive task- specific exercises ○ Gait and balance training ○ Bed mobility and sitting balance ○ Strengthening exercises
Part 2: Other Modalities	
Hydrotherapy: ☐ Yes ☐ No	Warm water-based exercises to assist with increasing muscle strength, reduce muscle/joint stiffness and pain, and therefore increasing mobility.
Functional Electrical Stimulation: ☐ Yes ☐ No	Use of electrical currents to activate paralysed, weak, or spastic muscles to improve functional movements such as sit to stand, reaching, or walking. Can be utilised in a cycling type activity or in isolation.
Wheelchair based/seated exercises: ☐ Yes ☐ No	Strength & conditioning exercises (e.g., weight machines, TheraBand, dumbbells, medicine balls): ○ Cardiovascular exercises (e.g., arm ergo, boxing) ○ Motor control exercises involving balance (e.g., throwing, catching) ○ General mobility training (e.g., transfer specific, stretching)

Part 3: Blood Pressure Monitoring	
Current resting BP:	_____/_____mmHg, _____HR
At NeuroMoves, our cut off BP to commence exercise is 160/100mmHg. If you are happy for your patient to exercise above this threshold, please inform the desired maximum BP.	_____/_____mmHg, _____HR **OR** ☐ No BP Issues
Monitoring of BP during exercise:	☐ Monitoring of BP is required pre or post exercise **OR** ☐ No monitoring of BP is required pre and post exercise

Additional Recommendations	
Current medication summary attached:	☐ Yes
Current relevant medical history attached:	☐ Yes
Additional recommendations for this client. Please outline:	

Your information	
Name:	*Place Doctor stamp here with your provider number:*
Signature:	
Provider Number:	
Date:	

Please give the completed report to your patient or send to info@scia.org.au or fax (02) 7202 0944. If you wish to discuss further, please do not hesitate to contact NeuroMoves on 1800 819 775.