



The Police Treatment Centres

Companion - Application to Accompany an In-Patient

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

Surname:		Forenames:		Date of Birth:	
(Preferred Name:)		Gender: M / F	
Address:			Contact details:		
Post Code:			Home telephone:		
			Mobile telephone:		
			Other telephone (state):		
			Email 1:		
Name of the person you wish to accompany:					
Surname:		Forenames:		Date of Birth:	
Relationship to the person you wish to accompany:					
Reason for request to accompany: Do you provide, or require, some aspect of support? If so please give full details					
Emergency Contact details: (e.g. next of kin – but NOT the person you wish to accompany):					
Name:			Relationship:		
Contact Details:					
Any specific room requirements: (e.g. mobility issues; more than 6 feet tall; Hearing impaired – re fire alarms; Weight etc):					
Any special dietary requirements: (e.g. allergies or intolerances):					

Companion - Medical Conditions If any:		Date of Diagnosis:
Companion - Medication/allergies/infections:		

Companion – Mobility and Access: Can you climb stairs / walk unaided? Please give distance. Are you 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:

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Will anyone else be attending: e.g. dependent children - Please give details, Name; Date of birth; medical condition (if any).

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Details of any dependents medication/allergies/infections:

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Your GP's Details

Dr:

Address:

Post Code:

Tel No:

Email:

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.
- 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.

Signature: Date:

Office Use Only:	
Date contact made by Nurse:	
Comments:	
Approved / NOT Approved:	Nurse Signature: Name: Date: