



# The Police Treatment Centres

## Application for Admission - INPATIENT

### PART 1 - To be completed by the applicant (please print)

<b>Surname:</b> .....	<b>Forenames:</b> .....	<b>Office Use Only</b>	
		Date received	
		Donation check	
<b>Any previous names:</b> Surname: .....		Date entered on system	
Forenames: .....		Date @ Nurse	
<b>Date of birth:</b> .....	<b>Gender</b> (please circle): <b>M / F</b>	Date @ Physio	
<b>Current police force, or if retired, previous force:</b> .....		1 <sup>st</sup> allocated	
		2 <sup>nd</sup> allocated	
<b>If serving:</b> Date joined: ..... Collar Number: .....		3 <sup>rd</sup> allocated	
<b>If retired:</b> Date of retirement: ..... Police Pension No: .....			
<b>Address:</b> ..... ..... ..... ..... .....		<b>Contact details:</b> Home telephone: ..... Mobile telephone: ..... Other telephone (state): ..... Email 1: ..... Email 2: .....	
<b>Post Code:</b> .....			
<b>Next of Kin - Name &amp; relationship:</b> ..... .....		<b>Next of Kin - Contact Details:</b> ..... .....	
<b>Admission Preference</b> (please tick): <b>St Andrews, Harrogate</b> <input type="checkbox"/> : <b><u>OR</u></b> <b>Castlebrae, Auchterarder</b> <input type="checkbox"/> :			
<b>Any specific room requirements:</b> (e.g. more than 6 feet tall; Hearing impaired – re fire alarms; Weight etc): .....			
<b>Any special dietary requirements:</b> (e.g. allergies or intolerances): .....			
<b>Dates to Avoid</b> (please include all leave/holiday, Court, or other known commitments):  			
<b>Can you attend at short notice?</b> (e.g. one week's notice) <b>YES / NO</b>		<b>Do you intend to stay at the Centre over the weekend</b> (If more than one week admission or retired officer) <b>YES / NO</b>	
<b>Legal Claims:</b> Have you any legal claims pending, or contemplated, in your current circumstance: <b>YES / NO</b>			

**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?:  
 .....  
 .....

Have you attended the PTC before?: <b>YES / NO</b>	If <b>YES</b> , when was your most recent attendance? .....
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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):  
 .....  
 .....

**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.**

<b>Diagnosis:</b>	<b>Date of Diagnosis:</b>
<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	

<b>Duration of symptoms:</b>
<p>.....</p> <p>.....</p>

<b>Underlying conditions/relevant medical history:</b>
<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

<b>Ongoing investigation/treatment:</b>
<p>.....</p> <p>.....</p>

<b>Nature/date of operations/scans/x-rays (please list):</b>	<b>Discharge date (if applicable):</b>
<p>.....</p> <p>.....</p>	

<b>Stress/psychological/psychiatric issue?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>
<b>Limited Mobility?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>
<b>Is Nursing assistance required with the 'Activities of Daily Living'?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>
<b>Does spouse/helper need to attend?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>
<b>Medication/Infections/Allergies?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>
<b>Is physiotherapy required?</b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If YES please complete <b>PART 4</b>

**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.

<b>Is the applicant receiving, or has the applicant previously received, counselling/psychiatric support?:</b>
<p>.....</p> <p>.....</p> <p>.....</p>

**Nursing care:** please expand on the nature of care required:

.....

.....

.....

**Medication/allergies/infections:**

.....

.....

.....

**Mobility:** Access requirements – can patient climb stairs / walk unaided / use wheelchair? Please give distance. Is patient full / partial or non-weight bearing? Expand fully on assistance level if needed on a daily basis and especially if at risk from falling:

.....

.....

**Spouse/carer:** What level of care can spouse provide? Please give full details of patient's requirements and carer's capabilities. Also indication of the general health of the spouse/carer and any dietary issues:

.....

.....

.....

**PART 5 - Signature of: Force Medical Officer or Occupational Health Nurse or Physiotherapist or G.P.**

**Certified by (signature):** ..... **Print name:** ..... **Date:** .....

Address: .....

..... Post Code: .....

Tel No: ..... Email: .....

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

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

**Certified by (signature):** ..... **Print name:** ..... **Date:** .....

Job Title: ..... Department: .....

Tel No: ..... Email: .....

Any other relevant information: .....

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

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

**Contact details:**  
 Tel: 01423 504448  
 Fax: 01423 527543  
 Email: [admissions@thepolicetreatmentcentres.org](mailto:admissions@thepolicetreatmentcentres.org)  
 Web: [www.thepolicetreatmentcentres.org](http://www.thepolicetreatmentcentres.org)