The Police Treatment Centres

Companion - Application to Accompany an IN-Patient

PLEASE NOTE THAT THERE WILL BE A COMPANIONS CHARGE OF £150 PER WEEK
(please refer to the PTC User Guide for further information)

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

Surname: **Forenames:** **Date of Birth:**

……………………………………….. ……… ………… ………………….……………

(*Preferred Name:*) **Gender:** **M / F**

Address:

…………………………………………………………….

…………………………………………………………..…

…………………………………………………...……

Post Code: ……………………………………………..

Contact details:

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 your request to accompany the applicant: Do you provide, or require, some aspect of support? If so please give full details

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Emergency Contact details: (*e.g. next of kin – but **NOT** the person you wish to accompany):*

Name: ……………………………………………………… **Relationship:** ……………………………………………………

Contact Details:

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Any specific accommodation requirements: *(e.g. Hearing impaired – re fire alarms; etc.):*

Height (if over 6')……………… Weight (if over 20 stone)…………..…… Other: ……………………….……………………

Any special dietary requirements: *(e.g. allergies or intolerances):*

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PART 2 - CONFIDENTIAL

Companion – Your Medical Conditions If any: **Date of Diagnosis:**

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Companion – Your 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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Companion - Your GP's Details:

Dr:

……..

Address: ....

.... Post Code: ....

Tel No: …... Email: ....

PART 3 – To be signed by the companion

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.

☐ I understand that there will be charge of £150 per week for my attendance as a companion and that this must be paid no later than the date of admission e.g. cheque or credit card payment before or upon arrival

Signature: .... **Date:**..

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