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| **C:\Users\registrar\AppData\Local\Temp\Temp1_AHPCSA logo.zip\Allied.jpgTHE ALLIED HEALTH PROFESSIONS COUNCIL****OF SOUTH AFRICA****CPD APPLICATION FORM – COMMUNITY CARE SERVICE**Please complete and submit this application to:e-mail: cpd@ahpcsa.co.za |
| **PERSONAL INFORMATION** |
| **FIRST AND LAST NAMES OF PRACTITIONER/THERAPIST** |  |
| **AHPCSA REGISTRATION NUMBER** |

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| **PROFESSION** |  |
| Postal Address |  |
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| **POSTAL CODE** |
| Telephone Number (Including Area Code)  |  |
| E-Mail Address |  |
| **NAME OF CARE CENTRE** |  |
| **VENUE ADDRESS** |  |
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|  |
| Date(s) of Activity/Programme |  |
|  |
| Duration of the community care activity (hours) |  |
| Specify the intended mechanism for monitoring attendance (per hour or per session) for the duration of the activity |  |
| **COMMUNITY CARE AT HEALTH CARE CENTRES / ORGANISATIONS:** Contact details: |  |
| TITLE**:** NAME AND SURNAME | Dr | Matron/Sister | Mr | Mrs | Ms |  |
| Postal Address |  |
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| Telephone Number (Including Area Code)  |  |
| E-Mail Address |  |
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| **AHPCSA: CONDITIONS FOR CPD ACTIVITY AT COMMUNITY HEALTH CARE CENTRES**Responsibilities towards the care centre1. The practitioner/therapist must report to the person in charge when arriving at, and leaving the care centre.
2. All procedures of the care centre must be followed.
3. Gowns must be worn if required.

Informed Consent to Therapy1. The practitioner/therapist must obtain informed consent to therapy before a treatment.
2. During the initial consultation with a patient, or any person responsible for maintenance of such patient, the practitioner/therapist must use a language that is reasonably understandable to the patient or their carer and must -
	1. give an accurate description of treatment protocol;
	2. state the number and frequency of treatment;
	3. advised of possible reactions after the treatment; and
	4. The practitioner/therapist must respect the patient’s autonomy and self-determination in that on receiving sufficient information regarding the treatment, the patient can decide whether or not to continue with the treatment.
	5. The practitioner/therapist must further respect the patient’s autonomy and self-determination in that they may choose to accept the treatment, or not, but also refuse to allow any anonymous details to be used if they do not wish their treatment to form part of a scientific body of literature for the growth of the profession.

Responsibilities towards Patients1. The practitioner/therapist must always recognise his/her responsibility towards a patient and at all times honour the principle that the treatment should be in the best interest of the patient.
2. The patient must be received and treated with respect, dignity, sensitivity, justice and with equality.
3. If any condition, medical or otherwise, requires referral for other appropriate treatment, this must be reported to the management of the care centre.

Confidentially1. Confidential information of a patient is of paramount importance and may not be released **without the consent** of the patient, parent or legal guardian of a minor patient.

Work in co-operation with other practitioners/therapists 1. The practitioner/therapist shall work in a co-operative manner with other health care practitioners/therapists and recognise and respect their particular contribution within the health care team, irrespective of the paradigm, conventional or otherwise.
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| ***PATIENT DETAILS*** ***[\*consent for disclosure to be obtained; if not granted indicate wish to remain anonymous]*** |
| ***\*First Name of patient*** |  |
| ***\*Last Name of Patient*** |  |
| ***Gender*** | ***Male*** | ***Female*** |
| ***Date of birth*** |  |
| **GENERAL CONDITION** | Mobile | Not mobile | Wheel chair | Bed ridden |
| Hearing conditions | Good  | Bad | Hearing Aid |  |
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| *SELECT CONDITION WHERE APPROPRIATE* |
| **Muscular/Skeletal problems:**  | Back Aches 🗌 Pain Stiff joints🗌 Headaches🗌  |
| **Digestive problems:**  | Constipation🗌 Bloating Liver/Gall Bladder🗌 Stomach🗌 |
| **Circulation:**  | Heart Blood pressure🗌 Fluid retention🗌 Tired legs🗌 Varicose veins🗌 |
| **Cellulite Kidney problems:**  | Cold hands and feet🗌 Borderline low blood pressure🗌 |
| **Other:**  |  |
| **Nervous system:**  | Migraine🗌 Tension🗌 Stress🗌 Depression🗌 Mild depression🗌Medication🗌 Chronic medication: Yes🗌 No🗌  |
| **Immune system:**  | Prone to infections🗌 Sore throats🗌 Colds🗌 Chest🗌 Sinuses🗌 |
| **Antibiotic/medication taken:**  | No🗌 Yes🗌 As needed🗌 Regular🗌 List: |
| **Chronic Medication:** | No🗌 Yes🗌 List: |
| **Herbal remedies taken:**  | No🗌 Yes🗌 List: |
| **Ability to relax:**  | Good🗌 Moderate🗌 Poor🗌 |
| **Sleep patterns:**  | Good🗌 Poor🗌 Average No. of hours 🗌 |
| **Food/vitamin supplements:** | No🗌 Yes🗌 List: |
| **Do you suffer from food intolerance/allergies?**  | Yes🗌 No🗌 If Yes list food: |
| **Is the diet balanced?** | Yes🗌 No🗌 Overweight: Yes🗌 No🗌 |
| **Smoking:**  | Yes🗌 No🗌 How many per day? 🗌 |
| **Alcohol intake:** | Yes🗌 No🗌 How many units per day? 🗌 |
| **Any exercise:**  | None🗌 Occasional🗌 Irregular🗌 Regular🗌 Types: |
| **Skin condition:** | Dry🗌 Oily🗌 Combination🗌 Sensitive🗌 Dehydrated🗌 Bedsores🗌 |
| **Conditions** **Present or past:** | Dermatitis🗌 Acne🗌 Eczema🗌 Psoriasis🗌 Number of years🗌 State of present or other Condition:  |
| Allergies🗌 Hay Fever🗌 Asthma🗌 Skin cancer🗌 Cancer🗌 TB 🗌 other Condition🗌 |
| ***STATE PRESENT CONDITION****:*  | Getting better🗌 Under control🗌 OTHER:  |
| **Stress level:**  | 1–10 (10 being the highest) 🗌 |
| **Reason for treatment:**  | Sinus congestion🗌 Headaches🗌 Stress🗌 Other Condition:  |
| **TREATMENT PLAN** |
| Date |  |
| Treatment | 1st | 2nd | 3rd | Other |
| **Patient information** |  |
| How does patient feel before the treatment. |  |
| **Protocol followed**  |  |
| Disinfection  |  |
| Any special focus area  |  |  |  |  |
| Reason for focus area |  |
| How does patient feel during the treatment? |  |
| How does patient feel immediately after the treatment?  |  |
| Specific advice given |  |
| **PRACTITIONER/ THERAPIST****SIGNATURE** |  |
|  |  |
| **DATE** |  |
|  |  |
| **CARE CENTRE****COMMENT (IF ANY)** |  |
|  |  |
| Number of people treated at facility |
| Reason or focus of community service |
| Length of treatments |
| Treatment plan for patient or structure of treatments for group |
| Findings and Outcome |
| **Overall Conclusion**Provide a brief overview of the experience and knowledge gained by this community care service against the background of your profession, how your scope of practice might be widened and deepened and how any national health plan might be changed to include the challenges faced by the patients or any other information you believe might be relevant so as to allow the AHPCSA to interact with the National Department of Health. |
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| **NAME OF DOCTOR/ MATRON/SUPERVISOR** |  |
| **SIGNATURE** |  |
| **DATE** |  |
| **OFFICIAL STAMP** |  |

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| **FOLLOW UP VISITS****DATE** | **COMMENT** | **RECOMMENDATION** |
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