MATES4MATES
Supporting Injured Defence Force Mates.

MATES4MATES APPLICATION.

Current & Ex-serving ADF Personnel..

This form is used to determine your eligibility to access the services at Mates4Mates.

Mates4Mates cares for our "Mates" who are current and ex-serving ADF personnel who have been physically and/or psychologically wounded, injured or ill as part of their Service with the ADF. Caring for our Mates also means caring for their families.

All information collected on this form is **confidential** and is used by Mates4Mates employees only. All personal information is kept secured and will not be shared with third parties without your permission. The only limits to confidentiality are threats of harm to yourself or someone else; or if a court subpoenas the documents.

1. Personal Details

Date of application: / /

Title: **Surname:** **Given Names:**

Preferred Names: **D.O.B**

Country of Birth: **Gender:** ☐ Male ☐ Female

Email: **Mobile:**

Home Ph: **Work Ph:**

Home Address:

Suburb: **Postcode:** **Country:**

Postal Address:

Suburb: **Postcode:** **Country:**

2. In Case of Emergency Contact

Name: **Relationship:**

Phone (M): **Phone (Home/Other):**

3. Service Status

☐ Current serving ADF ☐ Ex-serving ADF ☐ Current Reserve

In which service are/were you employed?

☐ Army ☐ Navy ☐ Air Force

Date Enlisted: **Date Discharged:**

Reason for Discharge: ☐ Own decision ☐ Medical ☐ Other:

If currently serving, which unit are you posted to?

Please nominate a POC at your unit:

FORM/MA/170202

CO's contact details: .....

Your PMKeys Number: ..... **Rank:** .....

Do we have your permission to contact them in order to seek approval for your involvement in Mates4Mates activities? ☐ YES ☐ NO

PLEASE NOTE: Mates4Mates will not make contact without your permission. Any personal information shared with Mates4Mates personnel is strictly confidential and will not be reported back. However, to participate in some of our activities, permission will be required from the ADF.

Have you deployed overseas? ☐ YES ☐ NO

Location: ..... **Year:** ..... **Duration:** .....

4. Your Health

Have you ever been diagnosed with/had any of the below conditions? (please tick)

- ☐ A musculoskeletal injury
- ☐ An Amputation
- ☐ Drug and or alcohol dependence
- ☐ Asthma
- ☐ Anxiety
- ☐ High blood pressure
- ☐ Cardiovascular disease
- ☐ Depression
- ☐ Post-Traumatic Stress Disorder
- ☐ Other Diagnosis: .....

Please provide the year of most recent diagnosis or injury.

Describe your wound, injury, or illness:

Has your wound, injury or illness impacted on you and or your family/friends? ☐ YES ☐ NO

If YES, how?

Has your wound, injury or illness impacted on your ability to work? ☐ YES ☐ NO

If YES, how?

IMPORTANT: If you don't identify with being wounded, injured or ill please speak to a Mates4Mates staff member before going any further in completing this form. Thank you

General Practitioner Name:

Do you receive treatment from any other health practitioner? ☐ YES ☐ NO

Have you submitted a DVA claim? ☐ YES ☐ NO

Have DVA accepted liability? ☐ YES ☐ NO

What is your DVA status?

5. About You

What are your reasons for contacting mates4mates?

☐ Support / mateship ☐ Family Support ☐ Psychological / Counselling

☐ Physical Rehabilitation ☐ Career Coaching ☐ Stress

☐ Involvement in programs ☐ Relationship issues ☐ Other

What interests do you and/or your family have? (e.g. sports, hobbies, family activities.)

Have you been involved in any Mates4Mates activities in the past? ☐ YES ☐ NO
(e.g. Kokoda Trek)

If YES, please provide details:

Other Comments?

6. Relationships & Family

What is your relationship status? (please tick)

☐ Married ☐ Single ☐ Divorced

☐ Widowed ☐ De Facto ☐ In a relationship

Number of Children : _____ **Are you their full time carer (if applicable)?** ☐ YES ☐ NO

Child 1. Name _____ DOB: _____ GENDER: _____

Child 2. Name _____ DOB: _____ GENDER: _____

Child 3. Name _____ DOB: _____ GENDER: _____

Child 4. Name _____ DOB: _____ GENDER: _____

CHILDREN'S DETAILS: This is collected only to provide Mates4Mates with information on how to best serve your family e.g. appropriate activities for family days.

If you have more than 4 children please include their details on a separate page and attach it to this application.

7. Marketing & Public Affairs

How did you hear about us?

☐ Word of Mouth ☐ Television ☐ Newspaper ☐ Referral: _____

☐ Other Mates ☐ Social Media ☐ Internet ☐ Other: _____

Would you be interested in representing Mates4Mates in the following? (This is voluntary)

PLEASE NOTE: You will be contacted on each occasion to determine if you are still interested / able.

☐ Photo and short Bio on website ☐ Media Interviews ☐ Publicity Events

☐ Other _____

8. What Happens Next?

Return your applications to your Family Recovery Centre.

- **Brisbane:** 27 Douglas Street, Milton QLD 4064 or PO Box 1220, Milton QLD 4064
- **Townsville:** 40 Anne Street, Aitkenvale QLD 4814 or PO Box 1334, Aitkenvale QLD 4814
- **Hobart:** 206 New Town Road, New Town, TAS 7008 or PO Box 34 New Town TAS 7008

If you need more information or have any questions please call **1300 4 MATES (62837)** or email **enquiry@mates4mates.org**

Thank you for completing this form

You will be contacted by a Mates4Mates staff member to discuss this application further.

Office Use Only

☐ All information collected ☐ Suitable for Mates4Mates

Approved: ☐ Yes ☐ No **Referred to:** ☐ Psychologist ☐ Doctor ☐ Exercise Phys

Name: _____ Signature: _____ Date: _____

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

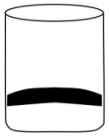
0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Australian Government
Department of Veterans' Affairs

Alcohol Screen (AUDIT)

THE RIGHT MIX

Light Beer 425ml 2.9% Alcohol	Full Strength Beer 285ml 4.9% Alcohol	Wine 100ml 12% Alcohol	Fortified Wine 60ml 20% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Can or Stubbie 375ml 4.9% Alcohol
					

The guide above contains examples of ***one standard drink***. A full strength can or stubbie contains ***one and a half standard drinks***.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

						Score	Sub totals
	Never	*Monthly or less*	*2 - 4 times a month*	*2 - 3 times a week*	*4 or more times a week*		
1. How often do you have a drink containing alcohol?	☐ Go to Qs 9 & 10	☐	☐	☐	☐		
	1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*		
2. How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐		
	Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*		
3. How often do you have six or more standard drinks on one occasion ?	☐	☐	☐	☐	☐		
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐		
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐		
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐		
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐		
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐		
	No		*Yes, but not in the last year*		*Yes, during the last year*		
9. Have you or someone else been injured because of your drinking?	☐		☐		☐		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐		☐		☐		
						TOTAL	

Supplementary Questions

	No	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

D0718 - 8/03 - P1 of 2