



Illness Support Holiday Program

The Paradise Kids Illness Support Holiday Program was established in April 2009 to offer families (from rural and remote areas, and other parts of Australia) with a child who has a terminal or life-limiting illness an opportunity to enjoy a one-week holiday. While here, the child and the family receive counselling and support to understand their feelings about the illness and the limits it places on their life. The program includes:

- illness support program
- sibling support
- emotional support for parents and extended family members

The program offers the whole family time to experience the beauty of the Gold Coast, with its many recreational facilities.

The Paradise Kids Illness Support Holiday House has two 3-bedroom units (one with wheelchair access) with a large communal family and kitchen area. The lovely beach theme throughout reflects the Gold Coast ethos and life style.

If you would like to know more about the Program or if you know of a family that meets the criteria then please contact Theresa McEwan, Illness Support Holiday Program Coordinator for a confidential discussion on:

T: 07 5574 6853

M: 0411 527 481

E: tmcewan@paradisekids.org.au

Alternatively, complete the attached Referral Form and return to:

Theresa McEwan
Illness Support Holiday Program Coordinator
Paradise Kids
PO Box 1290
Runaway Bay Qld 4214

Paradise Kids

88 Allied Drive Arundel Qld 4214

PO Box 1290 Runaway Bay Qld 4216

T: 07 5574 6853 F: 07 5563 3139

www.paradisekids.org.au

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Paradise Kids Illness Support Holiday Program Referral Form



Date of Referral: _____

Name of Referring Organisation: _____

Address: _____ Postcode _____

Contact Person: _____ Position: _____

E: _____ T: _____

FAMILY DETAILS

Family Name: _____ Child's Name: _____

Child's Illness: _____

Is the child aware of the nature of their illness?

Yes No

Does the child have any communication difficulties?

Yes No

If yes, please describe in a few words.

Is the child in a wheelchair?

Yes No

MOTHER OR LEGAL GUARDIAN DETAILS

First Name: _____ Surname: _____

Address: _____ Postcode _____

E: _____ T: _____

FATHER OR LEGAL GUARDIAN DETAILS

First Name: _____ Surname: _____

Address: _____ Postcode _____

E: _____ T: _____

MEDICAL SPECIALIST DETAILS

Name of Doctor: _____ T: _____

Address: _____ Postcode _____

Please provide a brief history of the family and the reason for the referral (please attach a separate sheet if required).

How many members of the child's immediate family would you like included in the Program? _____
(excluding the parents).

Please provide names, relationship to child and ages:

Name	Relationship To Child	Age

Do any of the family members have a disability or special needs? Yes No

If yes, please give a brief description.

Do any of the family members suffer a mental illness? Yes No

If yes, please give a brief description.

Is the family currently receiving services from the Department of Child Protection? Yes No

If yes, please give a brief description.

PLEASE NOTE

All information provided in this Referral Form will remain in the strictest of confidence.

Any of the above information requested will not be used to determine if a family is eligible for our services. The information requested allows us to plan more effectively in relation to the emotional support needed for the child and its family.

Before referring a family please ensure the child's illness will pass a medical clearance for air travel (where applicable).