

Please forward a copy of this application to the facility

Name of Facility _____ Date of Enquiry _____

RESIDENT DETAILS

NAME:

MR/MRS/MISS/MS/DR _____

AGE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____ SEX: _____

CURRENT ADDRESS: _____

ADMISSION FROM: HOME HOSPITAL HOSTEL NURSING HOME

REFERRED BY GP ACAT OTHER

COUNTRY OF BIRTH: _____

APPLICATION FOR: PERMANENT RESPITE URGENT

ROOM PREFERENCE: SINGLE ONLY SHARE CONSIDERED

HAVE YOU PREVIOUSLY BEEN IN A RESIDENTIAL AGED CARE FACILITY? YES NO

IF YES, NAME OF FACILITY _____ AND WHEN _____

ACAT ASSESSMENT: YES NO HIGH CARE LOW CARE RESPITE

APPROVAL DATE _____ NUMBER OF DAYS USED SINCE JULY 1st _____

[Copy of ACAT Assessment Form to be forwarded with this application form]

GP'S NAME _____ PHONE NUMBER _____

GP'S ADDRESS _____

IS GP ABLE TO CONTINUE CARE AT THIS FACILITY? YES NO

CONTACT PERSON

SURNAME _____ GIVEN NAMES _____

ADDRESS _____

TELEPHONE: Work _____ Home _____ Mobile _____

RELATIONSHIP TO THE APPLICANT _____

DIAGNOSIS / KNOWN MEDICAL CONDITIONS: _____

IS THERE A MENTAL HEALTH DIAGNOSIS? Yes No Details: _____

SPECIAL NEEDS: [including language, Oxygen and equipment] _____

SUPPLEMENTARY DIET: _____

WOUND CARE/SPECIAL TREATMENTS: _____

CARE REQUIREMENTS [dressing, continence, health conditions, mobility, behaviours i.e. confused, wandering etc.] _____

WHAT IS THE CURRENT WEIGHT OF THE RESIDENT? _____

IS SPECIAL EQUIPMENT REQUIRED? Yes No Details _____

DOES THE RESIDENT HAVE AN INFECTION? Yes No Details _____

IS THE RESIDENT A SMOKER? Yes No Details _____

PENSION AND BENEFIT DETAILS

Do you receive a Commonwealth Government pension Yes No

If **yes**, please indicate the type of pension Full Part

Age Disability Widows Blind DVA Overseas

Other _____

LEGAL AND FINANCIAL MANAGEMENT DETAILS

Have any of the following people been appointed on your behalf? If **yes**, please write name and contact number.

Guardian _____

Power of Attorney [financial] _____

Enduring Power of Attorney [administration] _____

Enduring Power of Guardianship [limited medical decisions] _____

Evidence sighted Yes No

Potential Resident/Relative to complete the following:

1. 5 steps to Entry into Residential Aged Care
2. Request for an Assets Assessment (in 5 step pack) to be sent to Centrelink – forward “Statement of Resident Status” letter from Centrelink if already received.
3. Asset Declaration Form (issued by Head office)
4. Direct Debit Form to be completed on admission

ACCOMMODATION BOND

Have you paid an Accommodation Bond to another facility? Yes No

If yes, please provide the following details:

Name of Facility _____ Amount of Bond \$ _____

If applicable, date of previous admission to Hostel or Nursing Home _____

Date of discharge from Hostel or Nursing Home _____

PRIVACY STATEMENT

Australian Privacy Laws regulate the way organizations handle your personal information. All information provided by you will be handled in the strictest confidence.

Completed By:

NAME: _____ SIGNATURE: _____ DATE: _____