ITALIAN VILLAGE
FREMANTLE

APPLICATION FOR ADMISSION

(TO BE COMPLETED BY RESIDENT/NEXT OF KIN)

APPLICATION DATE _____

SECTION ONE

SURNAME _____ CHRISTIAN NAMES _____

PREFERRED NAME _____

HOME ADDRESS _____

_____ POSTCODE _____

DATE OF BIRTH _____ ☐ FEMALE ☐ MALE

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

PENSION NUMBER _____ ☐ FULL ☐ PART ☐ NON

OVERSEAS PENSION / INCOME ☐ YES ☐ NO DVA _____

PRIVATE HEALTH COVER ☐ YES ☐ NO

FUND NAME _____ MEMBER NUMBER _____

MEDICARE NUMBER _____ SEQUENCE NO _____ EXPIRY DATE _____

(On admission you will be required to bring in your Medicare Card/Pension Card/ Private Health Insurance Card)

FIRST CONTACT

NAME _____ RELATIONSHIP _____

ADDRESS _____ POSTCODE .....

PHONE _____ WORK _____ MOBILE _____

SECOND CONTACT

NAME _____ RELATIONSHIP _____

ADDRESS _____ POSTCODE _____

PHONE _____ WORK _____ MOBILE _____

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SECTION ONE CONT.

PLACE OF BIRTH _____ AUSTRALIAN CITIZEN? ☐ YES ☐ NO

LANGUAGES SPOKEN _____ RELIGION _____

ARE YOU ON THE ELECTORAL ROLE? ☐ YES ☐ NO

DO YOU HAVE AN ENDURING POWER OF ATTORNEY ☐ YES ☐ NO

(if YES an original copy must be supplied for photocopying)

DO YOU HAVE A GUARDIANSHIP OR ADMINISTATION ORDER IN PLACE? ☐ YES ☐ NO

(if YES an original copy must be supplied for photocopying)

DO YOU HAVE AN ADVANCED HEALTH DIRECTIVE IN PLACE? ☐ YES ☐ NO

(if YES an original copy must be supplied for photocopying)

SECTION TWO

WHO IS YOUR USUAL TREATING DOCTOR? _____ PHONE _____

WILL DOCTOR CONTINUE TO TREAT YOU ONCE YOU ARE IN RESIDENTIAL CARE? ☐ YES ☐ NO

(THE FOLLOWING IS TO BE COMPLETED BY YOUR USUAL DOCTOR)

PAST MEDICAL HISTORY

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

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SECTION TWO CONT.

CURRENT MEDICAL PROBLEMS

1 _____

2 _____

3 _____

4 _____

5 _____

CURRENT MEDICATIONS/TREATMENTS

1 _____

2 _____

3 _____

4 _____

5 _____

IS ASSITANCE REQUIRED TO MANAGE MEDICATION AND TREATMENTS? ☐ YES ☐ NO

ALLERGIES _____

CURRENT TREATING SPECIALISTS / PHYSICIAN NAME _____

SURGERY _____ PHONE _____

DOES THE PERSON REQUIRE A SPECIAL DIET? ☐ YES ☐ NO

DIET _____

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SECTION THREE

ALCOHOL USE ☐ NIL ☐ LIGHT ☐ MEDIUM ☐ HEAVY

SMOKING ☐ NIL ☐ LIGHT ☐ MEDIUM ☐ HEAVY

MOBILITY

NEEDS SUPERVISION WALKING ☐ YES ☐ NO

INDEPENDENT ☐ YES ☐ NO

WALKING AIDS? ☐ YES ☐ NO TYPE _____

NEEDS PHYSICAL ASSITANCE WALKING ☐ YES ☐ NO

PLEASE SPECIFY _____

TRANSFERS

CHAIR ☐ INDEPENDENT ☐ SOME ASSIST ☐ FULL ASSIST

BED ☐ INDEPENDENT ☐ SOME ASSIST ☐ FULL ASSIST

TOILET ☐ INDEPENDENT ☐ SOME ASSIST ☐ FULL ASSIST

REQUIRES HOIST FOR TRANSFERS ☐ YES ☐ NO TYPE _____

DOES THIS PERSON HAVE OTHER SPECIAL AIDS? ☐ YES ☐ NO

IF YES, PLEASE TYPE _____

CONTINENCE

IS THE PERSON CONTINENT OF URINE? ☐ YES ☐ NO

IS THE PERSON CONTINENT OF FAECES? ☐ YES ☐ NO

AIDS TO MANAGE INCONTINENCE? ☐ YES ☐ NO TYPE _____

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SECTION THREE CONT.

COMMUNICATION

VISION ☐ GOOD ☐ FAIR ☐ POOR

GLASSES ☐ YES ☐ NO

HEARING ☐ GOOD ☐ FAIR ☐ POOR HEARING AID ☐ YES ☐ NO

SPEECH ☐ GOOD ☐ FAIR ☐ POOR

LANGUAGE DIFFICULTIES? ☐ YES ☐ NO

FIRST LANGUAGE _____

SOCIAL INTERACTION / PRESENTATION

IS THERE ANY EVIDENCE OF

☐ AGGRESSION ☐ DEPRESSION ☐ DEMENTIA ☐ ANXIETY

☐ WANDERING ☐ RESTLESSNESS ☐ CONFUSION ☐ NOCTURNAL DISTURBANCE

OTHER COMMENTS _____

_____

_____

HAS AN APPLICATION FOR APPROVAL FOR ADMISSION TO RESIDENTIAL CARE BEEN MADE TO A.C.A.T?

☐ YES ☐ NO ☐ HIGH CARE ☐ LOW CARE ☐ RESPITE

DATE APPLICATION MADE _____

DOCTORS DETAILS *(please use stamp)*

DOCTORS SIGNATURE

_____

DATE _____

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