



## 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 \_\_\_\_\_



**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 ADMINISTRATION 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)

<b>PAST MEDICAL HISTORY</b>	
1 _____	6 _____
2 _____	7 _____
3 _____	8 _____
4 _____	9 _____
5 _____	10 _____



**SECTION TWO CONT.**

**CURRENT MEDICAL PROBLEMS**

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_

**CURRENT MEDICATIONS/TREATMENTS**

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_

IS ASSISTANCE 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 \_\_\_\_\_

## 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 ASSISTANCE 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 \_\_\_\_\_



**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 \_\_\_\_\_