

APPLICATION / CHECK-IN FORM

WELLINGTON PARK PRIVATE CARE

Please attach a recent photo of the resident	Affix Resident Label here on Check-In
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Date of ACAT approval ___ / ___ / ___ - ___ / ___ / ___ (Please provide a photocopy of the ACAT form)

Approved for? High Care Low Care Dementia Specific Unit

Person to be placed on waiting list:

Surname: _____ Given Names: _____

Current Address: _____

Postcode: _____ Telephone: _____

Electoral Roll: Yes No Address on the electoral roll: _____

Next of Kin 1 (all correspondence relating to this application will be forwarded to this person):

(If this is the person requiring the aged care facility, then please write: **as above**)

(If this is the person who will be responsible for the account after admission tick here , if no please indicate an alternative person eg Next of Kin _____)

Surname: _____ Given Names: _____

Address: _____

Postcode: _____ Telephone: (work) _____ Telephone: (home) _____

Mobile: _____ Email address: (if applicable) _____

Relationship to the applicant: _____

Next of Kin 2:

Surname: _____ Given Names: _____

Address: _____

Postcode: _____ Telephone: (work) _____ Telephone: (home) _____

Mobile: _____ Email address: (if applicable) _____

Relationship to the applicant: _____

Next of Kin 3:

Surname: _____ Given Names: _____

Address: _____

Postcode: _____ Telephone: (work) _____ Telephone: (home) _____

Mobile: _____ Email address: (if applicable) _____

Relationship to the applicant: _____

Name and Signature of person completing form: _____

APPLICATION / CHECK-IN FORM

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Personal details:

1. Gender: Male Female
2. Date of Birth: ____/____/____ Age: ____ years
3. Marital Status: Married Widowed Defacto Divorced
 Single Separated
4. Religion / organisational affiliations (optional): _____
Country of Birth: _____ Language(s) _____
5. English Proficiency: Excellent Good Fair Poor Non English Speaking
6. Does the resident request assistance from staff with taking their medications? Yes No

Pension and benefit details (please provide a photocopy of these documents):

- Do you receive a Commonwealth Government Pension? Yes No
- If yes, please indicate the type of pension: Full Part Aged DSS DVA
 Widows Disability Blind
 Overseas (Please indicate Country) _____
 Other (please Specify) _____ Pension Number: _____

If no, please indicate source of income: _____

Do you have a Seniors Card? Yes No. If yes please provide the number: _____

Health Insurance and Medicare details (please provide a photocopy of these documents):

- a. Are you a member of a health fund? Yes No

Name of Fund: _____ Membership Number: _____

b. What is your Medicare Number: _____

c. Position Number on the Card: _____

d. Expiry Date: ___ / ___ / ___ e. Pharmaceutical Benefits Card Number: _____

Medical Officers details:

Current Medical Officer Name: _____ Contact Number: _____

Address of practice: _____

Will this doctor continue to look after the resident after check-in: Yes No

If no which Doctor will continue care: (Name, contact number and address of practice)

PHOTOGRAPH CONSENT

I, _____ on this day _____ give my consent / wish not (Please cross out your choice) to have my photograph taken for display purposes. I consent / refuse (Please cross out your choice) the use of my photograph for display within Wellington Park Private Care or externally.

Signed: (Resident) _____ Print Name Here: _____

Signed: (Representative) _____ Print Name Here: _____

Name and Signature of person completing form:

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Wandering / Absconding Resident

Is the resident at risk of wandering / absconding from the premises? Yes No
If yes are there any comments or instructions regarding the risk?

Legal and Financial Management details:

Have any of the following people been appointed on your behalf? **(Please provide a copy of the document)**

Guardian: Yes No Administrator: Yes No Power of Attorney (Financial): Yes No

Enduring Power of Attorney (Financial): Yes No

Enduring Power of Attorney (Medical Treatment): Yes No

If yes, please provide the name and address of persons you have appointed:

Surname: _____ Given Names: _____

Address: _____

Postcode: _____ Telephone: (H) _____ (W) _____ (M) _____

Other relevant details: _____

Do you have an Advanced Health Directive? Yes No **(Please provide a photocopy of this document)**

Funeral arrangements

Have you made funeral arrangements: Yes No

If yes, please provide the details of the Funeral Director to be called.

Name: _____ Telephone: _____

Address: _____ Postcode: _____

Please indicate your wishes: Cremation Yes Burial Yes

Any other arrangements? _____

Name and Signature of person completing form:

Office Use Only

Check-In Date: ___ / ___ / ___ From: _____

Wing: _____ Bed Number: _____

To be completed on Discharge

Discharge Date: ___ / ___ / ___ Discharge Time: ___ : ___ Discharge to: _____

If Deceased, Cause of death: _____ Body Infectious: Yes No

Doctors Name and Signature: _____ Death Certificate completed: Yes No

Pacemaker Present: Yes No Valuables on the body: _____

Body removed by: _____

HEALTH AND MEDICAL INFORMATION TO BE COMPLETED BY APPLICANT OR SIGNIFICANT OTHER

The purpose of this page is for you to give information that gives the aged care facility a general idea about the health and medical condition of the applicant.

Please tick the boxes next to the statements that best describe the health and medical condition of the applicant.

Walking and moving

- No assistance required_____
- Walking stick required_____
- Walking frame used_____
- Help from one person only to walk or move_____
- Help of two people to walk or move_____
- Unable to walk or move at all_____
- Recent falls (within last 12 months)_____

Showering and Grooming

- No assistance required_____
- Supervision and some assistance needed_____
- Need to be fully assisted with all aspects_____

Dressing

- No assistance required_____
- Supervision and some assistance needed_____
- Need to be fully assisted with all aspects_____

Eating

- No assistance required_____
- Some assistance required_____
- Supervision required_____
- Need to be fully assisted and supervised_____
- Special diet required_____

Continence

- No incontinence_____
- Occasional incontinence_____
- Frequent incontinence_____
- Catheter in place_____

Bowel Continence

- No bowel incontinence_____
- Occasional bowel incontinence_____
- Frequent bowel incontinence_____

Mental Ability

- Completely competent and oriented_____
- Some short-term memory loss_____
- Significant short-term memory loss_____
- Significant confusion and disorientation_____
- Unable to comprehend present life situation_____

Behavioural Problems

- Are there any behavioural problems?_____
- Please specify _____
- Does the person wander?_____

Communication

- Is the person able to see reasonably well?_____
- Can the person hear reasonably well?_____
- Can the person communicate through speech?_____
- Can the person comprehend what is being said?_____

Please outline a brief history of current illnesses or accidents

Please detail any known medical conditions

Any other comments you would like to make about this persons' health or medical condition

HEALTH AND MEDICAL INFORMATION TO BE COMPLETED BY THE MEDICAL PRACTITIONER.

Please tick the boxes next to the statements that best describe the health and medical condition of the applicant.

There is space for a comment next to each statement if you wish to use that instead or more information can be attached.

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