



**APPLICATION FOR ACCOMMODATION FORM:**

<b>Residents Details:</b>			
Last Name:	First Name:	Middle Name:	Gender: M / F
Address:		Phone No:	
Marital Status: M W S D	Spouse/Partner: (if applicable)		
Date of Birth:	Medicare No:	Exp Date:	Pos:
Pension No:	Exp Date:	<input type="checkbox"/> Full Pension	<input type="checkbox"/> Part Pension
Country of Birth:	DVA No:	Colour:	Exp Date:
Religion:	Language Spoken:	Interpreter: No	Yes
Health Fund Name:		Health Fund No:	
<b>Medical Practitioner:</b>			
My current General Practitioner (GP) is: Dr:			
Address:		Ph:	Fax:
Will you continue to see your GP when you enter the hostel: Yes / No			
If Yes: Will you GP visit you at the hostel: Yes / No			
<b>Specialists:</b>			
Dr:		Area of Speciality:	
Address:		Ph:	Fax:
<b>Next of Kin:</b>			
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Email:		<input type="checkbox"/> please tick if you wish to receive updates via email	
<b>Other Contacts</b>			
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Is there anyone whom we <b>should not</b> obtain personal or sensitive (including health) information from?			
Name:		Relationship:	
<b>Guardian / Power of Attorney</b>			
Guardian:		Power of Attorney	Enduring: No Yes
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
<b>Financial Management</b>			
Do you manage your own finances: Yes / No If No, who is responsible for managing your finances?			
Name:		Ph: (H)	(W) (M)
Address:			
<b>Estimation of assets: Less than \$49,000 \$49,001 – \$166,707 \$166,708 - \$402,121 More than \$402,122</b>			
<b>Estimation of assets is required to determine if you will need to pay Lump Sum Amount (RAD) on entry for permanent care.</b>			

**RESIDENTS' CARE NEEDS:**

Residents Name: .....

New residents entering Fitzgerald Aged Care must require a level of care. This care can be anything from supervision to full assistance and can vary between different aspects of care, i.e. personal hygiene, mobility, medication/treatments, etc.

To assist us in planning and meeting your care needs, please provide details of the care you require when you take up residence at the facility.

1: Do you have a preferred name?      Yes       No

If Yes, provide your preferred name: .....

2: Do you have any known allergies?      Yes       No

If YES, provide details of the care required: .....

.....

3: Do you require any assistance with dressing?

(Putting on certain clothes, bra, doing up buttons, etc)      Yes       No

If YES, provide details of the care required: .....

.....

4: Do you require any assistance with mobility?      Yes       No

If YES, provide details of the care required: .....

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5: Do you require any assistance with transfer?

(Assistance getting in and out of bed / chair)      Yes       No

If YES, provide details of the care required: .....

.....

6: Do you have any problems with eating or drinking that may require assistance?

Yes       No       If YES, provide details of the problem and management required:

.....

.....

Are you on any special diet? Yes  No

If Yes, type of diet: .....

Do you have any food allergies/intolerances? Yes  No

If Yes, Describe what foods you are allergic/intolerant to? .....

7: Do you wear Dentures? Yes  No

If YES, provide details: .....

8: Do you have any problems with you bowel or bladder? (Incontinence, catheter, requires pads, etc)

Yes  No  If Yes, provide details: .....

.....

9: Are you taking any medication/require any treatments? (Tablets, nebuliser, insulin, creams, eye drops, etc.)

Yes  No  If Yes, provide details: .....

.....

Will you require assistance with administering your medication? Yes  No

If Yes, provide details: .....

.....

10: Do you have any problems with your eyesight, hearing or speech?

If Yes, provide details: .....

Wears glasses Never  Always  Reading Only

Hearing Aid/s No  Left Ear  Right Ear

11: Do you have any memory problems? Yes  No

If Yes, provide details: .....

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12: Do you have a current ACAT Assessment? Yes  No

*If you have a current ACAT Assessment, please attach a copy of the referral codes to this application*

Name of person completing this form: .....

Relationship to resident: ..... Date: .....