



APPLICATION FOR ACCOMMODATION FORM:

Residents Details:			
Last Name:	First Name:	Middle Name:	Gender: M / F
Address:			
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:		
Medical Practitioner:			
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			
Specialists:			
Dr:		Area of Speciality:	
Address:		Ph:	Fax:
Next of Kin:			
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Email:		<input type="checkbox"/> please tick if you wish to receive updates via email	
Other Contacts			
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Is there anyone whom we should not obtain personal or sensitive (including health) information from?			
Name:		Relationship:	
Guardian / Power of Attorney			
Guardian:	Power of Attorney		Enduring: No Yes
Name:		Address:	
Relationship:	Ph:(H)	(W)	(M)
Financial Management			
Do you manage your own finances: Yes / No If No, who is responsible for managing your finances?			
Name:		Ph: (H)	(W) (M)
Address:			
Estimation of assets: Less than \$47,500 \$47,501 – \$162,087 \$162,088 - \$391,262 More than \$391,263			
Estimation of assets is required to determine if you will need to pay an Accommodation Bond on entry for permanent care.			

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:

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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:

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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:

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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:

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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:

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

Yes No If Yes, provide details:

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Will you require assistance with administering your medication? Yes No

If Yes, provide details:

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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: