



APPLICATION FOR ACCOMMODATION FORM:

Residents Details:			
Last Name:		First Name:	Middle Name:
Gender: Male / Female / Other, please specify:			
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:	
Aboriginal / Torres Strait Islander: No Yes		Ethnic Group:	Aboriginal / TSI tribe details:
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			
Next of Kin:			
Name:	Address:	Postcode:	
Relationship:	Ph:(H)	(W)	(M)
Email:	<input type="checkbox"/> please tick if you wish to receive updates via email		
Other Contacts			
Name:	Address:	Postcode:	
Relationship:	Ph:(H)	(W)	(M)
Name:	Address:	Postcode:	
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 \$49,500 \$49,501 – \$168,351 \$168,352 - \$406,053 More than \$406,054			
Estimation of assets is required to determine if you will need to pay Lump Sum Amount (RAD) 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: