FITZGERALD
AGED CARE
14 135 898 421

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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:	☐ Full Pension	☐ 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			

Person Responsible:			
Name:	Address:		Postcode:
Relationship:	Ph:(H)	(W)	(M)
Email:	☐ 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 **<u>should not</u>** obtain personal or sensitive (including health) infromation 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 assetts: ***Less than $61,500*** ***$61,501 – $206,039*** ***$206,040 - $495,118*** ***More than $495,119***

Estimation of assetts is required to determine if you will need to pay Lump Sum Amout (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: ……

……..

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: ……

……..

……..

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: ……

……

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: ……