

APPLICATION FOR ADMISSION TO A RESIDENTIAL AGED CARE FACILITY

MEDICAL INFORMATION SUMMARY

| | |
|---|---|
| Allergies and Alerts | <hr/> <hr/> |
| Contenance | <p>Bladder: Stoma <input type="checkbox"/> Continent <input type="checkbox"/> Uridome <input type="checkbox"/> IDC <input type="checkbox"/> Incontinence Pads <input type="checkbox"/></p> <p>Bowel: Stoma <input type="checkbox"/> Incontinent <input type="checkbox"/> Continent <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Mobility | <p>Independent <input type="checkbox"/> Able to use stairs <input type="checkbox"/> Ramps <input type="checkbox"/> Independent with walking aid <input type="checkbox"/></p> <p>Prosthesis <input type="checkbox"/> Wheelchair <input type="checkbox"/> Dependent <input type="checkbox"/> Wheelchair only <input type="checkbox"/></p> <p>Requires walking aid/prosthesis and assistance <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Vision | <p>Normal <input type="checkbox"/> Impairment <input type="checkbox"/> Complete vision loss <input type="checkbox"/> Glasses <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Hearing | <p>Normal <input type="checkbox"/> Impairment <input type="checkbox"/> Complete hearing loss <input type="checkbox"/> Hearing aids <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Does the applicant wander? | <p>Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Mental State | <p>Lucid <input type="checkbox"/> Confused <input type="checkbox"/> Aggression - Verbal <input type="checkbox"/> Physical <input type="checkbox"/></p> <p>Anxiety <input type="checkbox"/> Depression <input type="checkbox"/></p> <p>Cognitive Impairment Assessment conducted: Yes <input type="checkbox"/> No <input type="checkbox"/> date: _____ score: _____</p> <p>Diagnosed Dementia Yes <input type="checkbox"/> No <input type="checkbox"/> Type: _____</p> <p>Pre-existing mental illness Yes <input type="checkbox"/> No <input type="checkbox"/> _____</p> <p>Comments: _____</p> <hr/> <hr/> |
| Special Care Needs Other | <p>Oxygen <input type="checkbox"/> PEG <input type="checkbox"/> Wound Care <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Alcohol <input type="checkbox"/></p> <p>Smoker <input type="checkbox"/> Falls <input type="checkbox"/> Sleep patterns <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Special Dietary Needs <input type="checkbox"/></p> <p>Comments: _____</p> <hr/> <hr/> |
| Privacy and Release of Medical Information | <p>I _____ <i>(print name of applicant or carer/guardian)</i></p> <p>consent to the release of my medical details as contained in this document for the sole purpose of processing my enquiry, registration or admission to an Aged Care Facility.</p> <p>Signature: _____ <i>Applicant or carer/guardian</i></p> <hr/> <hr/> |
| GP Signature | <p>Signature: _____</p> <hr/> <hr/> |