lifecare
CHURCHES OF CHRIST

Form D

PERSONAL DETAILS FORM

Title ☐☐☐

Given Name

Other Names

Surname

Address

Gender Male ☐ Female ☐

Date of Birth ☐☐ ☐☐ ☐☐☐☐

Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐

Phone

Mobile

Religion

Minister/Priest Name

Phone

Language (s) Spoken

Interpreter required Yes ☐ No ☐

Electoral Roll Yes ☐ No ☐

Country of Birth

Pension Full ☐ Part ☐ Not Applicable ☐

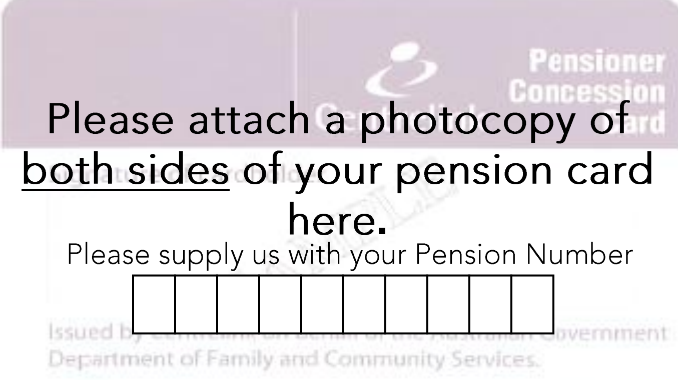
DVA Card Colour Gold ☐ White ☐ Other ☐

Safety Net No.

Medicare No.

Card Reference Number 1☐ 2☐ 3☐ 4☐

Expiry Date of Medicare Card ___ ___ /___ ___ /___ ___



Please attach a photocopy of both sides of your pension card here.

Please supply us with your Pension Number

Private Health Insurance Yes ☐ No ☐ Insurance Membership Number

Name of Fund Tables

Ambulance Fund Yes ☐ No ☐ Ambulance Membership Number

Diabetic Association Member Yes ☐ No ☐ Diabetic Membership Number

Access Cab Yes ☐ No ☐ Access Membership Number

Hearing Card Yes ☐ No ☐ Hearing Membership Number

Preferred Life Care Site - Aldinga Beach ☐ Reynella Lodge ☐ Parkrose Village ☐ Roselin Court ☐ Glenrose Court ☐

Treating Medical Practitioner (GP) Name

Address

Phone Mobile Fax

Will doctor visit the site when admitted? Yes ☐ No ☐ To be confirmed ☐

Surname | Given Names

Specified Relative/Person – 1st Contact

Name | Relationship to applicant

Address

Phone (Home) | Mobile | Phone (Work)

Email | Fax

Does the person have any of the following?
If Yes please provide a copy of the documentation.

- ☐ Power of Attorney
- ☐ Enduring Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Enduring Guardianship
- ☐ Executor of will/estate
- ☐ Trustee (Public)

Specified Relative/Person – 2nd Contact

Name | Relationship to applicant

Address

Phone (Home) | Mobile | Phone (Work)

Email | Fax

Does the person have any of the following?
If Yes please provide a copy of the documentation.

- ☐ Power of Attorney
- ☐ Enduring Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Enduring Guardianship
- ☐ Executor of will/estate
- ☐ Trustee (Public)

Specified Relative/Person – 3rd Contact

Name | Relationship to applicant

Address

Phone (Home) | Mobile | Phone (Work)

Email | Fax

Does the person have any of the following?
If Yes please provide a copy of the documentation.

- ☐ Power of Attorney
- ☐ Enduring Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Enduring Guardianship
- ☐ Executor of will/estate
- ☐ Trustee (Public)

Nominated Funeral Director Yes ☐ No ☐ Name | Phone

Anticipatory Directive (Schedule 2) in place Yes ☐ No ☐ ***If Yes*** please provide a copy of the documentation

Palliative Care Plan in place Yes ☐ No ☐ ***If Yes*** please provide a copy of the documentation

Surname Given Names

Optometrist / Ophthalmologist	Name		Phone
Physiotherapist	Name		Phone
Podiatrist	Name		Phone
Dentist	Name		Phone
Occupational Therapist / Speech Therapist	Name		Phone
Other Allied Health	Name		Phone
Audiologist	Name		Phone
Medical Specialist / s	Name		Phone
	Name		Phone
	Name		Phone
	Name		Phone

Disposal of Medication **(during placement in a Life Care Residential facility)**

I give consent for my prescribed medications to be returned to the pharmacy when no longer required for my use.

Name ………………………………… Signature …………………………….. Date ……………..

Please Note: Reimbursement for returned medications is not possible from the pharmacy service

In the event of a SUDDEN DETERIORATION IN HEALTH STATUS following placement, the applicant:

Action preferred

Wishes to be transported to a hospital Yes ☐ No ☐ If yes, Preferred Hospital

Wishes to be managed within the residential care facility Yes ☐ No ☐

Wishes to have each episode evaluated at the time Yes ☐ No ☐

Are there any specific cultural, religious or spiritual beliefs, which influence the applicant's terminal and after death wishes? Yes ☐ No ☐

If yes describe ……………………………………………………………………………………………

Surname [ ] Given Names [ ]

CONSENT TO RELEASE INFORMATION

Assessment for Accommodation involves regional Aged Care Assessment Teams (ACATs). The role of the Teams is to assess a person's needs and facilitate their access into appropriate residential and community services.

To accurately assess your needs, information regarding your medical and social situation needs to be shared between all people involved in this assessment. Churches of Christ Life Care Inc may liaise with the Aged Care Assessment Teams and accordingly we are required to ask you to sign giving your consent to release of this information.

RELEASE OF INFORMATION

I give my consent to Churches of Christ Life Care Inc, Aged Care Assessment Teams and other agencies to release social and medical information that will assist in an accurate assessment of my needs.

Name [ ]

Please tick

Signature [ ]

Applicant ☐ EPOA ☐ POA ☐

Witness Signature [ ] Name [ ] Date [ ]

OFFICE USE ONLY Information updated by staff

Commonwealth ID …………………

Date ACAT Submitted ……………………………

Date ………………… Staff Signature ………………………………… Name ……………….................

Updated with Name ……………………………………

Date ………………… Staff Signature ………………………………… Name ……………….................

Updated with Name ……………………………………

Date ………………… Staff Signature ………………………………… Name ……………….................

Updated with Name ……………………………………

Date of Admission: __ __ / __ __ / __ __ __ __

Site - Aldinga Beach ☐ Glenrose Court ☐ Parkrose Village ☐ Reynella Lodge ☐ Roselin Court ☐

Low Care ☐ High Care ☐ Respite ☐