Palmville Group Homes Pty Ltd

ABN: 41 682 841 814

Level 3 Residential Service

Resident's Admission Form

Form 4
Resident's Details

Resident's Full Name

Address PO BOX 503 BOOVAL QLD 4304

DOB | Marital Status | Gender M / F

Pension/Repat Number | Expiry Date: Day: Month:

Medicare No. | Expiry Date: Month: Year:

Private Health Fund Yes / No | Admission Date:

Health Fund Name | Date Of Leaving:

Membership No: | Paid in Advance: Weeks: Days: $

1 Next of kin / significant other / community support

Name | Relationship

Residential | Postal

Phone: (w) (ah) (mob)

2 Is there an existing case manager Yes / No

Name | Organisation

Phone: (w) (mob)

3 Does the resident have an appointed guardian Yes / No

If yes, go to question 6

Name | Organisation

Phone: (w) (mob)

4 Does the resident have an enduring power of attorney Yes / No

Name | Organisation

Phone: (w) (mob)

5 Who would act as statutory health attorney for the resident

Name | Organisation

Phone: (w) (mob)

6 Does the resident have a financial manager / administrator Yes / No

Name | Organisation

Postal Address:

Phone: (w) (mob)

7 Who is responsible for paying the service fees

Name | Organisation

Postal Address:

Phone: (w) (mob)

Level 3 Residential Service

Resident's Admission Form

Form 4A
Medical Details

1 **Standard Resident Assessment (Form 2) received from medical practitioner** Yes / No *(attach)*

Pls tick	Diagnosis / Disability	Comments
☐	Medical Illness	
☐	Psychiatric Disability	
☐	Developmental Disability	
☐	Sensory Disability	
☐	Other Disability	
☐	Dementia	
☐	Alcohol Related Brain Damage	
☐	Organic Brain Disease	
☐	Other Co-existing Illness or Disability	

Is the resident regulated under the Mental Health Act ? Yes / No

If yes, what section & details

1 Medical history

2 Current medical officer

Name _____ Surgery _____

Address _____

Phone: (w) _____ (mob) _____

3 Name of any specialists

Name _____ Surgery _____

Address _____

Phone: (w) _____ (mob) _____

Name _____ Surgery _____

Address _____

Phone: (w) _____ (mob) _____

4 Current medications

Name	Commenced Date	Duration (ie: 1 wk, continious)	Review Date
continue list on form 4E if insufficient room			

5 Known Allergies

Allergy to	Reaction	Action Required / Medication

1 Does the resident require assistance

Resident Requires Assistance	Yes / No	Comments
* to take **prescribed medication**	yes / no	
* to manage **financial affairs**	yes / no	
		if yes:
~ with personal budgeting	yes / no	budget:
		if yes ,should facility keep book / card in safe keeping
~ with bank book / key card	yes / no	yes / no . . . . comments
* with **personal mail** *(including opening mail received)*	yes / no	
* to manage **cigarettes / tobacco**	yes / no	
		if yes ,show often should the cigarettes be distributed
~ daily rate	yes / no / na	am / am & pm / am noon & pm / other
		other:
* with **shopping**	yes / no	
* at attend **medical or other appointments**	yes / no	
* to access **transport**	yes / no	
* to **clean own room**	yes / no	
* to do **personal laundry**	yes / no	

date: July 2000

1 Personal details

Religion _____

Preferred language _____

Cultural specifics _____

Current employment _____

_____

Current leisure / hobbies _____

_____

Food dislikes or
specific diet requirements _____

_____

Fears / phobias _____

_____

2 Referral agency

Referred by
Name _____
Agency _____
Phone _____ (mob) _____
Email _____

Crisis contact
Name _____
Agency _____
Phone _____ (mob) _____
Email _____

A / H contact
Name _____
Agency _____
Phone _____ (mob) _____
Email _____

4 Current medications

Name	Commenced Date	Duration (ie: 1 wk, continious)	Review Date
continued from Form 4, page 3			