



Avondale
Alstonville
Wyee Point
Jewells
LIFESTYLE COMMUNITIES

APPLICATION FOR ADMISSION

☐ Respite ☐ Permanent

Surname:	<input type="text"/>	Title:	<input type="text"/>
Given Names:	<input type="text"/>	Date of Birth:	<input type="text"/>
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widow <input type="checkbox"/> Widower <input type="checkbox"/> Defacto	Gender:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Intersex
Pension No:	<input type="text"/>	Expiry Date:	<input type="text"/> <input type="checkbox"/> Part <input type="checkbox"/> Full
Type of Pension:	<input type="text"/>		
Person Responsible:	<input type="text"/>		
Relationship:	<input type="text"/>		
Address:	<input type="text"/>	Postcode:	<input type="text"/>
Home Phone No.	<input type="text"/>	Mobile Phone No.	<input type="text"/>
Email:	<input type="text"/>		
Person responsible for fees/send account to:	<input type="text"/>		
Address:	<input type="text"/>	Postcode:	<input type="text"/>
Home Phone No.	<input type="text"/>	Mobile Phone No.	<input type="text"/>
Email:	<input type="text"/>		

Mail Distribution:

Official Business

Personal

To resident: ☐ ☐

To person responsible: ☐ ☐

Religion:	<input type="text"/>		
Clergy Visit:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Clergy:	<input type="text"/>
Medicare No.	<input type="text"/>	Expiry Date:	<input type="text"/>
Superannuation:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Super fund:	<input type="text"/>
Medical Fund:	<input type="text"/>	Medical Benefits No.	<input type="text"/>
Pharmaceutical Benefit Scheme # (PBS):	<input type="text"/>		
Current Address of applicant:	<input type="text"/>		
Phone Number:	<input type="text"/>		

The following information is required for government statistical purposes

Country of Birth: Aboriginal or Torres Strait Islander: ☐ Y ☐ N

Father's Full Name: Mother's Full name:

For office use only

Signature of Care Manager/Supervisor

Room No.

Date of admission:

Respite discharge date:

Name of Doctor:

Address: Postcode:

Phone No.

Allergies:

Date of last Pneumovax vaccinations: Date of last Influenza vaccination:

Does the applicant smoke? ☐ Y ☐ N Does the applicant drink alcohol? ☐ Y ☐ N

Does the applicant have an illicit drug dependency? ☐ Y ☐ N

Does the applicant have any supervision orders? ☐ Y ☐ N

Does applicant have a pacemaker? ☐ Y ☐ N

Does applicant have an implantable cardioverter defibrillator? ☐ Y ☐ N

Transport access scheme: ☐ Y ☐ N Ambulance membership #

Diabetic Association # Colostomy Association #

Does the applicant have a will? ☐ Y ☐ N

If yes, where is it lodged?

Executor/s:

Address:

Enduring Guardianship: ☐ Y ☐ N Power of Attorney: ☐ Y ☐ N

Enduring Guardian's Name: Power of Attorney's Name:

Contact Home Phone: Contact Home Phone:

Mobile: Mobile:

Does this applicant have an advance care directive? ☐ Y ☐ N

Funeral arrangements: ☐ Burial ☐ Cremation

Funeral Director: Body Donor: ☐ Y ☐ N

Has the applicant been assessed by an Aged Care Assessment Team? ☐ Y ☐ N

Has the ACCR been approved? ☐ Y ☐ N Date of ACCR approval:

How did you hear about us?

I have read, understand and agree to the terms of admission to the residential care facility as contained in the residents' charter and hand book.

Applicant/representative Name: Date of application:

Signature of applicant/representative:

Please supply the following documents to ensure a place on our waiting list:

- | | |
|---|--|
| <input type="checkbox"/> Completed Application Form | <input type="checkbox"/> Power of Attorney (if applicable) |
| <input type="checkbox"/> Aged Care Client Record (ACCR) | <input type="checkbox"/> Enduring Guardianship (if applicable) |