

AGED CARE FACILITY	Date
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RESIDENT DETAILS

Surname _____

Attach resident photo

Given name/s _____

DOB _____ **Age** _____ **Gender** M F

RESIDENT HEALTH INFORMATION

<p>Current diagnoses</p>	<p>Allergies</p>
<p>Reason for transfer. <i>Include events leading up to transfer</i></p>	<p>Expectation of transfer</p> <p><input type="checkbox"/> Admission <input type="checkbox"/> Family support</p> <p><input type="checkbox"/> Management review <input type="checkbox"/> Review and return</p> <p><input type="checkbox"/> X-ray</p> <p><input type="checkbox"/> Other:</p>
<p>Usual observations Date taken ____ / ____ / ____</p> <p>T ____ P ____ R ____ BP ____ BSL ____</p> <p>Weight ____ Other:</p>	<p>Palliative <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AHD/End of Life Care Plan <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Usual functionality	
<p>Cognition</p> <p><input type="checkbox"/> Alert Dementia:</p> <p><input type="checkbox"/> Oriented <input type="checkbox"/> No</p> <p><input type="checkbox"/> Short term memory loss <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Periodic confusion <input type="checkbox"/> Mild</p> <p><input type="checkbox"/> Nocte confusion <input type="checkbox"/> Mod</p> <p><input type="checkbox"/> Always confused <input type="checkbox"/> End stage</p> <p><input type="checkbox"/> Other:</p>	<p>Behaviours</p> <p><input type="checkbox"/> Cooperative <input type="checkbox"/> Spitting</p> <p><input type="checkbox"/> Not cooperative <input type="checkbox"/> Yelling</p> <p><input type="checkbox"/> Banging <input type="checkbox"/> Verbal aggression</p> <p><input type="checkbox"/> Rocking <input type="checkbox"/> Physical aggression</p> <p><input type="checkbox"/> Other:</p>
<p>Communication <i>(circle appropriate)</i></p> <p><input type="checkbox"/> Hearing Aid – Yes / No Left / Right With Pt: Yes / No</p> <p><input type="checkbox"/> Glasses – With Pt: Yes / No</p> <p><input type="checkbox"/> Dysphasia</p> <p><input type="checkbox"/> Aphasia</p> <p><input type="checkbox"/> Language Barrier – Yes / No</p> <p>Describe:</p>	<p>Mobility</p> <p><input type="checkbox"/> Independent <input type="checkbox"/> Wandering</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Hoist transfer</p> <p><input type="checkbox"/> 1Assist <input type="checkbox"/> Aids – Yes / No</p> <p><input type="checkbox"/> 2Assist Type:</p> <p><input type="checkbox"/> Stand transfer</p>
<p>Nutrition (Food)</p> <p><input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Smooth <input type="checkbox"/> Minced & most <input type="checkbox"/> Smooth pureed</p> <p><input type="checkbox"/> Diabetic <input type="checkbox"/> Low salt <input type="checkbox"/> Low protein <input type="checkbox"/> Other:</p> <p><input type="checkbox"/> Enteral feeding <input type="checkbox"/> NG/Peg <input type="checkbox"/> Dentures – Yes / No ; Full / partial ; With Pt : Yes / No</p>	
<p>Nutrition (Fluid)</p> <p><input type="checkbox"/> Regular <input type="checkbox"/> Mildly thick <input type="checkbox"/> Moderately thick <input type="checkbox"/> Extremely thick</p>	

<p>Elimination</p> <p><input type="checkbox"/> Continent – <input type="checkbox"/> Urine <input type="checkbox"/> Faecal</p> <p><input type="checkbox"/> Incontinent – <input type="checkbox"/> Urine <input type="checkbox"/> Faecal</p> <p><input type="checkbox"/> Aids – Yes / No</p> <p><input type="checkbox"/> Bottle <input type="checkbox"/> Commode <input type="checkbox"/> Urodome</p> <p><input type="checkbox"/> IDC <input type="checkbox"/> Incontinence pads</p> <p>Date of last bowel motion:</p>	<p>Hygiene</p> <p><input type="checkbox"/> Independent <input type="checkbox"/> Aids</p> <p><input type="checkbox"/> Set up <input type="checkbox"/> Static chair</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Mobile chair</p> <p><input type="checkbox"/> Partial assist <input type="checkbox"/> Bed bath</p> <p><input type="checkbox"/> Full assist <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Sponge in bed</p>
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RESIDENT DETAILS

Address _____

First language _____

Religion _____

Private health Yes No. Fund _____

Level of cover _____

Pension# _____ Exp _____

Medicare# _____ Exp _____

FACILITY DETAILS

Type Nursing home Hostel Secure Unit Independent living

Facility name _____

Wing/unit _____

Address _____

Contact name _____

Ph (in-hrs) _____ Ph (a/hrs) _____

Fax _____

Email _____

GP DETAILS

GP name _____

Address _____

Contact name _____

Ph (in-hrs) _____ Ph (a/hrs) _____

Fax _____

Email _____

Notified of transfer Yes No

PHARMACY DETAILS

Does resident have: Webster pack Sachet pack Other

Facility name _____

Contact name _____

Address _____

Email _____

Ph (in-hrs) _____ Ph (a/hrs) _____

Fax _____

NEXT OF KIN / STATUTORY HEALTH AUHTORITY / EPOA

<p>1st contact _____</p> <p>Relationship _____ EPOA <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Phone (H) _____ (W) _____</p> <p>Mob _____</p>	<p>2nd contact _____</p> <p>Relationship _____ EPOA <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Phone (H) _____ (W) _____</p> <p>Mob _____</p>
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EPOA: Statutory Health Authority (if different from above)

Name _____ Relationship _____

Phone (H) _____ (W) _____ Mob _____

Resident social alerts

Completed by: _____ **Time/Date:** _____ **Position:** _____