Resident Admissions Data

Title: _____ **First Name:** _____ **Middle Name:**_____

Surname: _____ **Preferred Name:** _____ **D.O.B:** _____

Address: _____ **P/CODE** _____ **Phone:**_____

Gender: ❑ Female ❑ Male **Marital Status:** ❑ Married/Defacto ❑ Widowed ❑ Single ❑

Aboriginal or Torres Strait Islander: ❑ Yes ❑ No **Country of Birth:** _____

Primary Language: _____ Secondary Language: _____ ❑ N/A

Interpreter Needed? ❑ Yes ❑ No Religion: _____ ❑ N/A

Medicare Number: _____ Card member No: _____ Exp.date: ____ / ____

Name that appears on Medicare card: _____

Pensioner Status: ❑ Full ❑ Part ❑ N/A Centrelink Number: _____

Exp date: ____ / ____

DVA Number: _____ ❑ N/A Transport Access Scheme: ❑ Yes ❑ No

Private Health Insurance Provider: _____ Membership Number: _____

Nominated Funeral Director: _____ Phone Number: _____

❑ Burial ❑ Cremation ❑ Special Religious Needs _____

Primary Contact: First Name: _____ Surname: _____

Relationship to Resident: _____ Address: _____

P/Code: _____ Contact Phone Number: _____ Work: _____

Mobile: _____ Email Address: _____

Secondary Contact: First Name: _____ Surname: _____

Relationship to Resident: _____ Address: _____

P/Code: _____ Contact Phone Number: _____ Work: _____

Mobile: _____ Email Address: _____

Next of Kin: Same as Primary Contact: ❑ Yes

❑ If No First Name: _____ Surname: _____

Relationship to Resident: _____ Address: _____

P/Code: _____ Contact Phone Number: _____ Work: _____

Mobile: _____ Email Address: _____

Resident has a Power of Attorney: ❑ No ❑ Yes - *Specify Type:* ❑ General ❑ Enduring

Power of Attorney First Name: _____ Surname: _____

Power of Attorney Telephone Number: _____ Mobile: _____

Name of Solicitor: _____ Phone No: _____

Nominated Medical Practitioner: Doctor _____ Phone No: _____

Does the Resident have any Allergies: ***i.e. Food or Medication?*** ❑ **No** ❑ **Yes**

Specify Allergy:

❑ Food allergy: _____

❑ Medication allergy: _____

❑ Other allergy: _____

Diabetic: ❑ No ❑ Yes Diabetic Association Number: _____

Please specify any particular dietary requirements: _____

_____

Signature: _____ Print name: _____ Date: _____