# GREEN FORM

***Level 3 Residential Service***
**Resident's Admission Form**

**Form 4**
**Resident's Details**

Resident's Full Name

Address

| 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 ____________________

# Form 4B Relevant Medical History

## 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 |
|---|---|---|
| | | |
| | | |
| | | |

**Level 3 Residential Service**
# Resident's Admission Form

**Form 4C**
**Services Required**

## 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 | |
| | | |

## 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* | | | |
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