WEEROONA
AGED CARE RESIDENCE

OFFICE USE ONLY — Application Form

Enquiry Date:	Wing:	**Placement Required**:
	Aged Care ID	
	Care Rec ID	☐ Permanent ☐ Respite Care
..... / ..... /	MRN ….….....	

* Please fill in as much of the Application Form as you can. If there is any part that you are having difficulty completing, please let us know, we are more than happy to help you fill the sections out.

1 Applicant Details (Person requiring residential care)

Title: DOB:

Surname: First Name:

Second Name: Preferred Name:

Nationality: Religion: Relationship Status:

Home Address: Post Code:

Telephone: Mobile:

Email:

Do you identify as LGBTIQ? Gender: ☐ Male ☐ Female

Do you identify as Aboriginal or Torres Strait Islander?

Permanent Referral Code:

Respite Referral Code:

Medicare: __ __ __ __ - __ __ __ __ __ - __ (__) Expiry:

Status: ☐ Full Pensioner ☐ Part Pensioner ☐ Non-Pensioner

Pension: __ __ __ - __ __ __ - __ __ __ __ Expiry: DVA: __ __ __ __ __ __ __ __ __ Expiry:

Copy of Centrelink Assets Assessment Letter: ☐ Yes ☐ No

Notes:

Phone: (02) 6342 3333 **Email:** admissions@wacr.care **Website:** www.weeroonaagedcare.com.au
Address: 10 Comerford Street, Cowra NSW 2794

2 First Contact (N.B: First Contact will be the person notified of any changes or issues)

First Name: Surname:

Address: Post Code:

Telephone: Mobile:

Email:

Relationship to the Applicant:

Authority (e.g. POA, Enduring Guardian, NSW Trustee, Guardianship)

Has a copy of this document been provided? ☐ Yes ☐ No

3 Accounts and Correspondence

I nominate the following person to receive all correspondence:

☐ Myself (Applicant) ☐ Other

First Name Surname:

Address: Post Code:

Telephone: Mobile:

Email:

4 Second Contact

First Name: Surname:

Address: Post Code:

Telephone: Mobile:

Email:

Relationship to the Applicant:

Additional Notes:

5 Current General Practitioner Details

Dr's Name:

Telephone: Mobile:

Email:

Address

Post Code:

Do you give your family permission to request your medical records? ☐ Yes ☐ No

6 Allied Health Details

Name:

Field: (e.g. Audiologist, Heart Specialist):

Telephone / Mobile:

Email:

Address

Post Code:

Name:

Field: (e.g. Audiologist, Heart Specialist):

Telephone / Mobile:

Email:

Address

Post Code:

7 Specialised Nursing Information

Allergies:

Reactions:

Does applicant have a peg feed? ☐ Yes ☐ No Requirements?

Does the applicant use an oxygen concentrator? ☐ Yes ☐ No

Has the applicant had Pneumovax injections? (2 in a lifetime) ☐ Yes ☐ No

Applicant's current location? ☐ Home ☐ Hospital ☐ Another Nursing home

Does applicant use hearing aids?

Provider & last audiologist appointment:

Does applicant have dentures?

Provider & last dental appointment:

Does applicant wear glasses?

Provider & last optometrist appointment:

8 Other Information

If you need an interpretor to assist you, please write the language you speak:

Are there any cultural, religious or other organisations you would like to remain in contact with?

If so, please list them:

Please advise if you have any cultural, religious lifestyle or medical requirements

eg. Medical / Dietary Needs:

Please attach: Discharge Summary and Health Summary

9 Facility Accommodation & Services

What type of accommodation do you require? Private Suite ☐ Yes ☐ No

Shared Room ☐ Yes ☐ No

Would you like information about an additional or extra service place? ☐ Yes ☐ No

Have you received any respite care since the start of the financial year? ☐ Yes ☐ No

If yes, how many days have you received?

Name of Applicant:

Signature: Date:

Authorised person signing on behalf of applicant:

Name:

Signature: Date:

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