



Admission Enquiry Record

Please place Resident information Label here

Resident:	
DOB:	
Admission Date:	

Permanent residential care

Respite residential care

Prospective resident information

Full name:	
Date of birth:	
Address:	
Phone contact (1):	
Phone contact (2):	
Current location:	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Residential Aged Care
Medicare Card Number:	
Pension / DVA Number:	
Religion:	<input type="checkbox"/> Christian <input type="checkbox"/> Church of Christ <input type="checkbox"/> Catholic <input type="checkbox"/> Anglican <input type="checkbox"/> N/A <input type="checkbox"/> Other – Please Specify _____
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single

Contact Information

Next of Kin:	
Relationship:	
Address:	
Phone contact (1):	
Phone contact (2):	

Residential care approval information

Approval:	<input type="checkbox"/> High Care <input type="checkbox"/> Low Care <input type="checkbox"/> Respite
Date of Approval:	
Copy of Current ACAT Attached:	
Expiry of Approval (low care):	
Facility sighted by:	

Health Information

Diagnoses: (Please provide as much information as possible)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia related illness?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Able to walk (independently or with aids)

