



# James Milson Village

<b>ADMISSION ENQUIRY</b> <b>CR 1</b>	Potential Resident's Surname:

 *This form is to be completed during interview with prospective resident(s)/primary carer(s)*

## SOURCE OF ENQUIRY

(please tick ✓)

- |   |  |
|---|--|
| <input type="checkbox"/> Prospective resident   | <input type="checkbox"/> Social worker - acute care facility |
| <input type="checkbox"/> Primary carer          | <input type="checkbox"/> Social worker - other               |
| <input type="checkbox"/> ACAT                   | <input type="checkbox"/> Medical practitioner                |
| <input type="checkbox"/> Other (specify): _____ |  |

Date of enquiry: \_\_\_\_\_

Name of person making enquiry: \_\_\_\_\_

Contact Number: (home) \_\_\_\_\_

(work) \_\_\_\_\_

(mobile) \_\_\_\_\_

(Email) \_\_\_\_\_

Appointment: date: \_\_\_\_\_ time: \_\_\_\_\_

## TYPE OF ACCOMMODATION SOUGHT

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> High care | <input type="checkbox"/> Respite - from: _____ to: _____ |
| <input type="checkbox"/> Low care  | <input type="checkbox"/> Permanent                       |
| <input type="checkbox"/> Self care |  |

## APPLICANT DETAILS

### A. Personal Details

Surname: \_\_\_\_\_

Given Name(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Last Known Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Medical Practitioner: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Current Location:  Home: \_\_\_\_\_  
 (please tick ✓)  Hospital: \_\_\_\_\_  
 Other: \_\_\_\_\_


Pension Status:  Non  Part  Full

Pension Type: \_\_\_\_\_

Accommodation Charge/Bond Status: \_\_\_\_\_

Centrelink Assets Form: \_\_\_\_\_

**B. Health Status**

 **Sections B and C of this form ONLY need to be completed for those prospective residents seeking residential care services**

Diagnosis: \_\_\_\_\_

Level of assistance required with activities of living:

(please tick ✓)

	none	some	major	extensive	
i) washing/dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ii) toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
iii) eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
iv) mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
v) communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Continence status: bladder: \_\_\_\_\_

bowel: \_\_\_\_\_

Sensory status: vision: \_\_\_\_\_ aids: \_\_\_\_\_

hearing: \_\_\_\_\_ aids: \_\_\_\_\_

Cognitive status: \_\_\_\_\_

Behaviours: \_\_\_\_\_

**C. Special Needs**

(please tick ✓)

	yes	no	
Special diet:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric feeding:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wound care:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urine drainage:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oxygen therapy:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nebuliser therapy:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Secure environment:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:			_____


Speaks/understands English:  Yes  No Primary language spoken: \_\_\_\_\_  
 Special cultural/religious requirements: \_\_\_\_\_

Smoker:  Yes  No

**D. Visit Checklist**

<i>(please tick ✓)</i>	yes	no	n/a
Tour of facility conducted:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facility Information Pack provided:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial Declaration Form issued: <i>(residential care services only)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed/unit availability discussed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Security of Tenure discussed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fees and Charges discussed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. Authority for Placement**

 **Sections E of this form ONLY needs to be completed for those prospective residents seeking residential care services**

Commonwealth 3020 approved high/low care *(please circle)*  
 permanent/respite *(please circle)*

Approved: *(date)* \_\_\_\_\_  
 Accessing ACAT: \_\_\_\_\_  
 Interviewer: \_\_\_\_\_  
*(print name)*  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Once completed, file in Admission Enquiry Folder.**

**FOLLOW UP CONTACT**

Date	Comment


Date appropriate bed/unit available: \_\_\_\_\_ Unit/Room No: \_\_\_\_\_  
Date place offered to applicant: \_\_\_\_\_  
Applicant accepted:  Yes  No  
Admission date: \_\_\_\_\_  
Pre admission leave required:  Yes  No Days: \_\_\_\_\_  
*(residential care services only)*

**On admission, file in Resident's Clinical/Personal Records.**