

Applicant's Name D.O.B.

Is the applicant at present a patient of a hospital or other organisation? Yes No

If yes, name of organisation

District NurseContact No.

Day Care - Where.....

Current Medical History -

Current Problems

Medication/Treatment

1.....

2.....

3.....

Past Medical History - Past Problems

1. 2.

3. 4.

5. 6.

ALLERGIES ?

Past or present notifiable infectious disease (e.g. T.B., Viral Hepatitis, H.I.V.)? Yes No

If yes, please give details

Has the applicant been assessed by a Psychogeriatrician ? Yes No

If no, does the applicant require an assessment ? Yes No

(A Psychogeriatric Assessment is a preferred requirement for placement in a secure dementia environment.)

OTHER CURRENT SPECIALIST/PHYSICIANS

Name Speciality

Medication assistance: Unnecessary Currently supervised Necessary

DIET

Does the applicant require a special diet ? Yes No Type

Details: None Light Medium Heavy

Alcohol Use

Smoking

Applicant's Nursing And Personal Care Requirements

(To be completed by Registered Nurse or Medical Practitioner)

MOBILITY Walks Use Frame/ Assistance Assistance
 unaided tripod of 1 person of 2 people
 requires or wheelchair or bedfast
 supervision

FUNCTIONAL PROFILE: Independent Needs Assistance Dependent
 (able to perform (supervision (requires complete
 without assistance) assistance of 1) assistance)
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Transfer bed/chair walking aids/wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting Device	<input type="checkbox"/>
Bathing/showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dressing/Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Eating/Drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tube Fed	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catheter	<input type="checkbox"/>
				Colostomy	<input type="checkbox"/>

INCONTINENCE **Never** **Occasionally** **Night Only** **Always**

Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faeces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MENTAL STATE **Never** **Occasionally** **Night Only** **Frequently**

Disorientated/Confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive Behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMUNICATION (Please tick)

VISION	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	
AIDS	Contact Lens <input type="checkbox"/>	Glasses <input type="checkbox"/>	Other <input type="checkbox"/>	
HEARING	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Hearing Aid <input type="checkbox"/>
COMPREHENSION	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	
FUNCTIONAL SPEECH	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	

CULTURAL & LANGUAGE BACKGROUND _____

SPECIALISED NURSING PROCEDURES:

Dressings Inhalation Therapy Palliative Care

Other _____

Comments _____

Accommodation considered best to suit applicant's need:
 Semi-independent (Hostel level) Dependent (Nursing Home level)

Has an approval form for an Aged Care Facility been submitted to the Aged Care Assessment Team ? Yes No

Signed Medical Practitioner _____
 (Please print or stamp) Name _____
 Address _____
 Phone _____ Date _____