Enquiry/Application for Respite or Permanent Care

Personal details

Surname		**First name/s**		
Preferred name you would like to be called:				
Gender: (please circle)	Female	Male		Non-Binary
Date of birth				
Relationship status	Married / Life partner	Single	Widowed	Divorced / Separated
Do you identify as Aboriginal or Torres Strait Islander? (please circle)	Yes	No	Prefer not to specify	
Do you identify with a specific cultural or religious background?	Yes	No	Details:	
Is English your first language?	Yes	No	Details:	
Where were you born?				
What is your current address?				
Are you currently living at this address? (Please circle)	Yes	No		
If not, where are you currently living / residing / staying?				

Type of care

Which type of care are you seeking? (Please circle)	Respite	Permanent	Palliative Care
If you are seeking respite, what time frame are you wanting?			
When would you like to come into Eloura?			
Is there an urgent reason for admission? (Please describe)	Yes/No		
Who is your current GP?			

Address and contact details

Have you confirmed that your GP is able to continue to provide medical care after entry to Eloura?	Yes	No (If no your enquiry will not be able to progress)	

Financial details

Do you receive a pension?	Yes	No	DVA
	Full	Part	Self-funded retiree
Please provide your pension card number			No applicable
Please provide your DVA card number			Not applicable
What is the expiry date of your card?			
What is your Medicare number?			Position number:
If you are a member of private health fund, please provide: **Fund name** **Type of cover** **Policy number**			

What type of accommodation are you seeking?	Single room	Shared Room	No preference
Would you be able to pay a Refundable Accommodation Deposit? (please circle)	Yes	No	Unsure
Shared room with ensuite **Single room with ensuite (Level G and 2)** **Single room with ensuite (Level 3)**	$180000.00 $350000.00 $300000.00		

Health and medical details

Please list your current and pre existing medical conditions **(please ensure you include a current health summary – including medications and vaccination history – from your GP with this form)**			
Please answer the following questions based on your needs on your worst day			
Do you require any assistance to help you walk or mobilise	Yes	No	
What type of assistance do you require? **(Please circle**	None	Someone watching	Someone to help / support me
	Walking stick	Walking frame	Wheelchair
	Unable to walk – I require a specialised chair or am bed bound		
How far can you walk (with or without assistance? **(Please circle)**	5 metres	10 metres	20 metres
	50 metres	I can walk a long distance without needing to stop	
Do you require any assistance to move from sitting to standing (ie move from bed to chair or on/off toilet)? (Please circle)	Yes	No	
What level of assistance do you need? **(Please circle)**	None	Someone watching	Some to help / support me
	Lifting device	What sort of device do you use?	
Are there any changes to your memory or cognition?	Yes	No	Sometimes
Do you get confused or disorientated?	Yes	No	Sometimes
Please describe your memory or cognitive changes and the impact that it has on your life and day to day activities ***Please include any changes to personality or behaviour***			

Do you have any or require any specialised medical treatment? **(Please circle as applicable)**	Oxygen therapy	Wound care	Urinary catheter care
	Medication by injection	Enteral feeding	Stoma care
	Tracheostomy care	Peritoneal dialysis	Skin care / pressure injury
	Other:		
Current Weight:			
Have you had recent weight loss?	Yes	No	Unsure
If so, how much weight have you lost over the last 3 months.			
Do you have any special dietary requirement	Yes	No	
If yes, please describe. **(Diabetic, soft diet, thickened fluids, specialised utensils, assistance to eat meals etc)**			
Can you roll over in bed independently?	Yes	No	
Have you had any recent falls?	Yes	No	
If yes, how many times have you fallen in the last 12 months			
Do you have any changes to bladder or bowel function or experience any incontinence of urine or bowels?	Yes	No	Sometimes
Do you use incontinence aids?	Yes	No	Sometimes
Please describe the types of incontinence aids you use, or the continence changes you have. ***Please include any support you need to go to the bathroom.***			
Do you require any assistance to shower and dress each day?	Yes	No	Sometimes
Please describe what sort of help you need			
Do you drink alcohol?	Yes	No	Sometimes
Do you smoke?	Yes	No	Sometimes
Are you up to date with your vaccination program?	Yes	No	Unsure

Please write the date that you had the following vaccinations	COVID 19 Influenza Pneumonia Shingles	

Legal considerations		
Do you have an Enduring Guardian	Yes	No
	Name: Address Contact No. Email Name: Address: Contact no: Email:	

Do you have an Enduring Power of Attorney? ***If more than one, please write details on the last page.***	Yes	No
	Name Address Contact No. Email	
Who would you like us to contact in an emergency? ***If you have more than one person, please write details on the last page***	Name Contact No Relationship to you.	
Are you under the care of the NSW Public Trustee or Guardian	Yes	No

If yes, please provide details			
Do you have an Advanced Care Directive?	Yes	No	Unsure
Do you have a current will?	Yes	No	Unsure
Are you still on the electoral roll?	Yes	No	Unsure
Do you have preferred funeral director?	Yes	No	
If yes, please provide name and contact details			

My Aged Care details			
Have you had an ACAT assessment?	Yes	No	Unsure
Please write the code supplied to you for the following services	Respite code		
	Permanent code		
Please write you Aged Care Number	AC		

Please write any other information you think we should know about you

Did you fill out this form yourself	Yes	No
If No, please write the name and contact details of the person who completed this form, as well as their relationship to you.		

Signature	Date:

Please write below, any other information you wish to share with us.