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Aged Care Facility Registration and Consent Form

Please complete in BLOCK capitals or type

Title: Mr / Mrs / Miss / Ms / Dr Gender: M / F / Other Marital Status: _____

Family Name: _____

Given Name: _____

Date of Birth: _____

Aged Care Facility Name: _____

Address: _____

Phone: _____ Fax No: _____ Email: _____

Room No: _____

Are you (please circle) Aboriginal Torres or Strait Islander Ethnicity: _____

Main Language:_____

Interpreter required Y / N

Name Registered with Medicare: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ IRN No.: _____ Expiry: _____ / _____

Pension / DVA number: _____ Expiry: _____

NEXT OF KIN DETAILS

Name: _____ Relationship: _____

Address: _____ Post code: _____

Home / Mobile Number: _____

Email: _____

Next of kin consents to being contacted (please circle): Yes / No / NA

Additional contact person: _____ Contact details: _____

ADMINISTRATION

Medical Power of attorney & contact details: _____

_____

Legal power of attorney if different from above: _____

_____

MEDICAL HISTORY (Including Dementia, Diabetes, Hypertension, Stroke)

_____

Mobility (please circle) walking independently / uses 4WW / Bedridden / Other

MEDICATION LIST – Please attach medication list

ALLERGIES

_____

SOCIAL HISTORY (SMOKING & ALCOHOL)

Smoker: Y / N if Yes how many / day: _____

Alcohol intake: _____

ADVANCED CARE PLAN & WISHES

Does that patient have an advanced care plan (please circle): Y/ N

If so, please state last review and patients end of life wishes: _____

_____

_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____

Relationship to patient: _____

Home phone no: _____ Work phone no.: _____

CONSENT TO BULK BILL & ADMIN FEES

Hospital Street Doctors have my consent to provide bulk billed services as per item numbers displayed in figure 4, page 61 of the 4th edition of the Medical care of older persons in residential aged care facilities (RACGP Silver Book) and I understand and agree with any updates that may follow to the Medicare Benefits Schedule relevant to my care. (See attached document from the RACGP Silver Book available at http://www.racgp.org.au/guidelines/silverbook) I also acknowledge that there may be no Medicare rebates for some administrative tasks related to my care and I may therefore be required to cover these costs.

CONSENT TO USE PATIENT INFORMATION

Furthermore, I understand that Hospital Street Doctors comply with the privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Hospital Street Doctors collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates. I understand I may withdraw my consent for Hospital Street Doctors to use and disclose my personal information (except when legal obligations must be met).

Patient / Legal guardian signature: _____

Date: _____