



Amber Aged Care

New Resident Forms





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The Admission Checklist For Consumer

This checklist is to assist you to familiarise yourself with a facility:

1. Plan of the facility
2. Your room, Living Area, Dining Room tour
3. Activity Building tour.....
4. Outside Area tour
5. Meal Time. Menu.....
6. Meal Price for family member
7. Emergency Exit, fire plan evacuation
8. Financial Matters with office Staff.....
9. NOK information, address, payment options with Office staff
10. Laundry Name Tags expenses
11. Laundry Service
12. Security Code for the family Members
13. Lifestyle Activities Program
14. Hairdresser Service, Bus Service / Shopping / Lunch Trips.....
15. Internet Access: Wi-Fi password; Phone rent.....
16. Compliments and Complaints Policy and Procedure.....

CONSUMER / NOK

Name (print):

Signature:

Date:

Induction Carried Out by

Name (print):

Signature:

Date:

Tables Of Other Care And Services (Itemised)

Tables A and B below list the range of other care and services available to residents of Amber Aged Care.

Table A lists the other care and services provided by of Amber Aged Care.

Table B lists the other care and services to which access may be facilitated by the approved provider but are provided by an external agency or contractor.

Other care and services are not covered by the resident's fees and payments (ie standard fee, means tested care fee and accommodation payment or accommodation contribution), hence the resident may be required to pay an additional charge for the relevant other care or service.

The specific costs for the other care and services listed in Tables A and B are provided upon booking, either by clinical staff (for care services) or administration (for recreational services). However they are subject to change and the resident will be advised of the full cost prior to their agreeing to receive the relevant other care or service.

Table A: Provided by the Approved Provider Who Determines Costs

Type of Other Care	Cost	Details of Other Care	
Off-site Medical Appointment Escorts and social outings	\$35 per hour	Amber Aged Care staff to accompany residents to, during and from appointments, facilitated by the Home.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Daily Newspaper	Cost	Delivered to Room	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phone	\$15 per month		<input type="checkbox"/> Yes <input type="checkbox"/> No
Outings including Lunches at Pubs	Actual Cost incurred at Venue/Travel	Lifestyle staff will accompany residents to Pub Lunches, and care for them whilst there. That is free of charge, but lunch to be paid from resident's own accounts.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Labelling	\$2 per item, minimum order of 50 labels		<input type="checkbox"/> Yes <input type="checkbox"/> No

Table B: Provided by External Agencies or Contractors Who Determine Costs

Type of Other Care	Cost	Details of Other Care	
Dentist	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Physiotherapy Services	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Optometrist	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Dietician Services	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Speech Pathologist Services	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Newspapers	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hairdresser	Determined by Contractor on booking	Organised by Amber Aged Care's clinical staff and facilitated on-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please speak to Nursing staff about the range of 'facility-pays' Allied Health services on site

Consumer Personal & Significant Details

Type of Admission: Permanent Respite Date of Admission: Room:

ACAT No: Date of Discharge:

Title: Preferred Name: Surname Name:

Given Name: Date of Birth:

Marital Status: Married Single Divorced De-facto Widowed

Admitted from (Home, Hospital etc.):

Last Fixed Address: Postcode:

Mobile No. (if applicable): Home No. (if applicable):

Emergency Contacts

Consumer Affairs are Managed by: Consumer Family Member Guardianship Board Power of Attorney

Primary Contact

Name:

Address: Postcode:

Phone (home): Business: Mobile:

Email:

Relationship to Consumer:

Next of Kin POA Responsible for Fees Managing Affairs Receive Mail

Second Contact

Name:

Address: Postcode:

Phone (home): Business: Mobile:

Email:

Relationship to Consumer:

Next of Kin POA Responsible for Fees Managing Affairs Receive Mail

Third Contact

Name:

Address: Postcode:

Phone (home): Business: Mobile:

Email:

Relationship to Consumer:

Next of Kin POA Responsible for Fees Managing Affairs Receive Mail

Power of Attorney

Name of Power of Attorney:

Address: Postcode:

Phone: Mobile: Email:

Next of Kin Responsible for Fees Managing Affairs Receive Mail

Medical Practitioners & Specialists

Amber Aged Care's RCF GP:

Previous GP:

Practice & Address:
 Phone: Fax:

Dentist:

Eyes:

Other Specialists:

Other Specialists:

Country of Birth:

Main Language: Able to Read Able to Write

Second Language: Able to Read Able to Write

Religion: Name of Preferred Clergy: Phone No:

Pension No: Exp Date: Type: DVA

Medicare No: Exp Date:

Ambulance No:

Health Fund Name: Health Fund No:

Previous Pharmacy Details:

Preferred Hospital:

Transport Vouchers Location of Vouchers:

Other Questions

<p>Is the Consumer the recipient (or have they been in the past, or will they again be in the future) of a Compensation Entitlement payment?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you have answered yes to this question, we need to pass this information on to the Department of Social Services before admission in order to receive a correct letter from Centrelink regarding the Means Tested Care Fee.</p>
<p>Is the Consumer a self-funded retiree?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you have answered yes to this question, we need to pass this information on to Centrelink before admission in order to receive an assets assessment letter from them, to determine the Means Tested Care Fee, the assessment of which is compulsory when entering Aged Care.</p>
<p>Where did you hear about Amber Aged Care?</p>	<p><input type="checkbox"/> Friends and Relatives <input type="checkbox"/> Family Member has been a consumer</p> <p><input type="checkbox"/> Community Events <input type="checkbox"/> Community Group</p> <p><input type="checkbox"/> Other Health Professionals <input type="checkbox"/> My Aged Care Website</p>

I submit that the information I have entered on this Form to be true and accurate to the best of my knowledge. I agree that I have sought help in understanding the content of this Form (if it has been needed) and that my concerns have been clarified by staff.

Signed (Consumer / representative): Name:

Date of Birth: Relationship to Consumer (if applicable):

Terminal Directives

Resident Full name:

Date: Time:

Names of Family Members involved in the completion of this form:

.....



Are there any funeral arrangements? Yes No Name of Funeral Director:

Phone No: Address:

1. In the event of a sudden crisis / health deterioration, does the resident or significant other have any special wishes?
 e.g. not to be hospitalised, if hospitalised to return to facility as soon as possible?

2. If, in the event there was a gradual deterioration, does the resident / significant other wish palliative care to be provided by the facility with ongoing discussion with the family and Doctor?
 e.g. not to be hospitalised, if hospitalised to return to facility as soon as possible?

3. What are your wishes in relation to resuscitation? For Full Resuscitation Not For Resuscitation

4. Are there any requirements in relation to artificial means of prolonging life?

5. In the event of death or sudden deterioration, would the significant other wish to be notified at any time?
 If so, who is to be notified?

6. In the event of death, are there special requirements in regards to the body?
 If so, what are the requirements, e.g. previous arrangement for post-mortem or organ donation, burial / cremation

7. Are there special wishes, religious or cultural practices regarding viewing of the body, special oils, outfit, etc., after death?

8. Are there any special fulfilling requests or wishes that the resident or family wish to achieve prior to death?
 e.g. visit to family home, certain food, religious rituals and visit from long lost family members / friends

9. Would you like to have the last rites?

10. Any other special wishes?

Name: Signature:

Relationship: Date:

Name: Signature:

Relationship: Date:

Consent To Act As Advocate

Resident / Consumer Details

Full Name: Date of Birth:

I authorise the person/s named below to act as an advocate on my behalf and represent my interests in relation to my involvement with Amber Aged Care. I understand that Amber Aged Care may discuss details of "My Plan" (Care Plan) and the services it provides with my advocate if the need arises.

Exclusions include:
.....
.....

This takes effect from and replaces any previously advised arrangements. I understand that I can change my choice of advocate at any time and undertake to advise Amber Aged Care of any such change.

Advocate's Details

Full Name: Address:

Phone No: Relationship:

As an advocate of the above-mentioned person I undertake to ensure that:

- It is the consumers wishes that I act as their advocate and will provide written consent if available. e.g. Advanced Care Directives or EPOA.
- I will always act in the best interests of the resident / consumer.
- The resident / consumer will be made aware of any issues and developments in relation to the support they receive and which I, as their advocate, may be involved.
- I will familiarise myself with contents of the resident / consumer's care and services needs
- I am familiar with the resident / consumer's "Charter of Rights" and will promote these to the resident / consumer.
- I will advise Amber Aged Care about any changes in the residents / consumer's circumstances and any concerns about their changing needs.
- I am prepared to relinquish the role of advocate should the consumer wish this.

Other Persons

I also consent to the following people being provided with information regarding the care and services I am receiving.

.....
 Care Plan Incidents Medication Management Finances Other

.....
 Care Plan Incidents Medication Management Finances Other

.....
 Care Plan Incidents Medication Management Finances Other

.....
 Care Plan Incidents Medication Management Finances Other

Consumer Signature

Signature: Date:

Consent To Care Recipient / Consumer Information

Resident / Consumer Name:

I consent to Amber Aged Care collecting Personal Information about me. I understand that the purpose of the collection of this information is required for use in providing services.

I understand Amber Aged Care may use the information for purposes related to their services and may disclose information to other persons such as: specialist medical practitioners, physiotherapists, allied health professionals, pharmacists, pharmacists undertaking medication reviews RMMRs, pathology, radiology or organisations/ consultants which require the information to provide services directly related to Amber Aged Care its residents / consumers and the services being provided. I have no objection to this.

I do not wish the following persons to have information disclosed to them:
.....
.....
.....

To my photograph being taken for use in newsletters and publications by Amber Aged Care.

I consent I do not consent

To information about the organisations services / products fund raising activities etc., being sent to me.

I consent I do not consent

I have signed this consent after:

- A member of Amber Aged Care staff has fully explained to me of the need for information about me to be collected, the nature of that information, the purposes for which it will be used and how it will be protected;
- The secondary purposes referred to above have been explained to me;
- I have had explained to me my rights to verify information held about me and my rights to access that information;
- I believe that I fully understand my rights to privacy in respect of information collected, used and disclosed about me and my rights of access to that information.

Name of Care Recipient: Signature:

Relationship to Care Recipient: Date:

- Enduring Power of Attorney
- Enduring Power of Guardianship
- Has a copy of these orders been provided

Personal Clothing Identification

Please note that Consumers' clothing labelling system is compulsory, and Amber Aged Care will not take responsibility for any lost item if not named.

You, as a family member could label clothing prior to admission or at the earliest convenience, if not, labelling will be undertaken by Amber Aged Care (AAC) at the following cost to Consumer:

AAC will order 50 labels for each Consumer, and in case more labels required, the family will be contacted.

Cost of each label will be \$2.00 which will cover the printed label and its application.

Management

Agreement On The Maximum Accommodation Payment

I, (resident or resident's representative), acknowledge that Amber Aged Care Inc (the approved provider) has given me a Resident Agreement, which includes an Accommodation Agreement, in respect to the admission of (the resident) as a permanent resident of Amber Aged Care Residential Service (the service).

I further acknowledge, a member of the approved provider's staff, has explained the terms of the Resident Agreement to my satisfaction.

I understand an accommodation payment or accommodation contribution may be payable to the approved provider by the resident for their occupancy of an approved place in the service and that the maximum accommodation payment amount is \$ (this means the accommodation payment amount cannot exceed \$). The actual accommodation payment amount the resident is to pay is to be agreed by the resident or their representative and the approved provider prior to or on the resident's day of permanent admission to the service.

I understand the resident or their representative is to inform the approved provider in writing of the accommodation payment (or accommodation contribution) method of payment within 28 days after admission. The method of payment may be a:

- refundable deposit, which if the maximum accommodation payment was paid in full by refundable deposit, would be \$; or
- daily accommodation payment, which if the maximum accommodation payment was paid in full by daily payment, would be \$ per day; or
- combination of a refundable deposit and daily accommodation payment, for instance a refundable deposit of \$ and a daily payment of \$ per day.

I understand that until the resident informs the approved provider of their chosen payment method, the method of payment will be a daily accommodation payment.

Resident's Name: Resident's Signature:

Representative's Name: Representative's Signature:

Representative's Address:

Staff Name: Staff Signature:

Position/Title:

Approved Provider: Amber Aged Care Residential Service

Residential Aged Care Service: Amber Aged Care

Price Agreement Day Date:

Accommodation Payments and Accommodation Contributions

Prudential Disclosure Requirements

Dear

As part of the conditions applying to your admission to Amber Aged Care Residential Service (the service), you have paid or agreed to pay an accommodation payment or accommodation contribution.

The Commonwealth Government's prudential requirements ensure protection of residents' accommodation payments and accommodation contributions paid by refundable deposit. Should you elect to pay your accommodation payment or accommodation contribution in full or part as a refundable deposit, then within 7 days of a request by you, we will provide you with information about our compliance with these prudential requirements including our investment management strategy, a summary of the permitted uses we have applied and refund provisions. We will also provide a copy of the most recent statement of the service's audited accounts, of the independent audit opinion concerning compliance with prudential requirements and of entry(s) in the refundable deposit register that relate to you at the time of your request.

Unless otherwise stated the information and documents will pertain to the financial year preceding the date of your request.

These documents and information are provided under Part 4, Division 1, Subsection 15(a) and Part 5, Division 5, Section 57 of the Fees and Payments Principles (No. 2) 2014.

Yours sincerely

ECO
Amber Aged Care

Payments

Payments can be made by Bank Transfer or Cheque made out to Amber Aged Care.

Bank Transfers can be arranged as a direct deposit into a bank account through your bank's branch or online services.

BSB: 085 458
Account Number: 55025 4283
Account Name: Amber Aged Care
Description: Your Surname

28 Day Letter

I as representative for the resident
agree to facilitate the payment of the Accommodation Costs associated with my 's care via the following method:

- Refundable Accommodation Deposit (RAD)
- Daily Accommodation Payment (DAP)
- A combination of the two: PART RAD AMOUNT:
- PART DAP %:
- PART DAP AMOUNT:.....

Name: Signature:

Relationship to Resident: Date:

Payments can be made by:

Office Use Only
Date of Permanent Admission: Date of 28 Day Expiry: Within time frame
Signature: Position:

Flu Vaccine Consent Form

Dear Resident / Family Member,

Flu season is fast approaching. We will be contacting doctors in coming weeks to arrange for annual flu vaccinations for their patients.

Permission of administration must be given prior to receiving the flu vaccine. Please indicate on the tear off slip below that you give consent for this vaccination to be administered and return to Janet Hill Clinical Services Coordinator or Reception desk at your soonest convenience, as we are unable to administer any flu vaccines without consent.

Please see attached fact sheet to assist you with making an informed decision.

Please return Consent Form below by / /

Kind Regards



Flu Vaccine Consent Form

Name of Resident:

Resident Signature:

Relative / Representative Name (if resident unable to give consent):

Relationship to Resident:

Tick one:

- I consent to receive the Flu Vaccine
- I do not consent
- I give consent for my family member, named above, to receive the Flu Vaccination

Signature: Date:

Office Use Only

Name: Relationship:

RN Name: RN Signature:

Date:

Pharmacy Admission - Account Details

Haddad Pharmacy Group (Unley)
160 Unley Road
Unley SA 5061
Ph: 82712343
Fax: 8271 2010
Email: accounts@haddadpharmacygroup.com.au

Pharmacy Account Details

Send Account to (Person's name):

Street Address:

Suburb: Postcode:

Phone Number: Email:

Please indicate if you would like the account emailed: Yes No

I,, accept responsibility for the full payment of the pharmacy account for (Resident's name), at (Faculty name) for medications provided by Haddad Pharmacy Group (Unley). In the event of a default in payment of greater than 60 days, I am aware that my account may be sent to a debt recovery agency for which I may also incur a service charge.

Signature:

Haddad Pharmacy accounts begin from 26th of each month through to 25th of the following month. Payment options are included with each account. These include:

- Direct Debit facility
- Electronic Transfer of Funds
- Credit Card payment
- Cheque payment.

Haddad Pharmacy has a designated Accounts Department, who are happy to assist with any account queries or concerns you may have. The direct contact number for account queries is 8464 6662, alternatively, any queries can be emailed directly to accounts@haddadpharmacygroup.com.au.

Pharmacy Admission - Personal Details

Haddad Pharmacy Group (Unley)
160 Unley Road
Unley SA 5061
Ph: 82712343
Fax: 8271 2010
Email: accounts@haddadpharmacygroup.com.au

Pharmacy Admission Notice

Date: Facility: Section:

Title (Mr, Mrs, etc.): First Name: Surname:

Date of Birth: Weight:

Allergies:

Doctor: Phone Number:

Medications: Liquids Only Crushed Whole Tablets

Pharmaceutical Benefit Entitlement Details: Please Tick the appropriate entitlement card.

None Pension Concessional Repatgold Repat White

Previous Pharmacy Name: Phone Number:

Pension Number: Expiry Date:

Safety Net Number: SN.....

Medicare Number: Patient Number on card:

Medicare Number Expiry Date:

Generic substitution: I wish to take advantage of generic substitution where available

Yes No

Notes: Signature:

Valuables Check List

Please list if the Consumer has any of the following on admission:

Appliances: (e.g. Radio, Television, Cassette Recorder, Video Recorder, Cassettes, Games etc.)

Type and description:

.....

.....

.....

.....

.....

Maintenance request for test and tagging completed: Yes No

Furniture: (describe):

.....

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Special or personal items: (Ornaments, photo frames, etc.):

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Jewelry: (Wrist watch, rings, etc.- describe colour of metal/stones etc):

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Money or valuables: (Wallet, purse, cards, cash):

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Other Items:

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NB: Amber Aged Care insurance does **NOT** cover resident’s personal belongings or money. If you wish to have these valuables insured, please make your own arrangements. Any valuables kept by the consumer are kept at their own risk.

This form must be completed and signed by the admitting **Registered Nurse.**

Name: Signature: Date:

Consumer or representative:

Name: Signature: Date:

Items brought to the home after admission:

Date:	Other Items
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.....
.....



Amber
Aged Care

58 Avenue Road Paradise SA 5075

Phone: 08 8465 5500 **fax:** 08 8365 3723

www.amberagedcare.com.au

 [amber-aged-care](https://www.facebook.com/amber-aged-care)