

Waters Edge Level 1, 2-8 Lake Street Caroline Springs VIC 3023 Tel: 1300 317 071 Fax: (03) 8610 1011 Email: admin@doctoredcare.com.au  <b>Doctor Aged Care</b> A.B.N 93433952780	<b>AGED CARE FACILITY REGISTRATION &amp; CONSENT FORM</b>			
	Please complete in <b>BLACK BLOCK</b> capitals or type			
	Title: Mr / Mrs / Miss / Ms / Dr	Gender: M / F / Other	Marital Status:	
	Name:			
	Surname:			
	Date of Birth:			
	Address:			
	Phone:	Fax No:	Room No:	
	Aboriginal	Torres Strait Islander		
	Ethnicity:	Main Language:		
Pension / DVA number:	Interpreter required	Y / N		
Medicare Number:	Expiry:			
<b>NEXT OF KIN DETAILS</b>				
Name:		Relationship:		
Address:		Post code:		
Home / Mobile Number:		Email:		
Next of kin consents to being contacted		Yes / No / NA		
Additional contact person:		Contact details:		
<b>ADMINISTRATION</b>				
Medical Power of attorney & contact details:				
Legal power of attorney if different from above:				
<b>MEDICAL HISTORY</b> (Including Dementia, Diabetes, Hypertension, Stroke)				
<i>Mobility please circle:</i> walking independently / uses 4WF / Bed ridden / Other				
<b>MEDICATION LIST</b>				
<b>ALLERGIES</b>				
<b>SOCIAL HISTORY (SMOKING &amp; ALCOHOL)</b>				
Smoker: Y / N, if Yes how many / day				
Alcohol intake:				
<b>ADVANCED CARE PLAN &amp; WISHES</b>				
<b>Does that patient have an advanced care plan: Y/N</b>				
<b>If so please state last review and patients end of life wishes:</b>				
<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no:	Work phone no.:	
<b>CONSENT TO BULK BILL &amp; ADMIN FEES</b>				
<p>Doctor Aged Care and associated health care providers have my consent to provide bulk billed services as per item numbers displayed in figure 4, page 61 of the 4<sup>th</sup> 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. Also available at <a href="http://www.racgp.org.au/guidelines/silverbook">http://www.racgp.org.au/guidelines/silverbook</a></p> <p>I also acknowledge that there are no medicare rebates for administrative tasks related to my care and I may therefore be required to cover these costs such as those related to referral, repeat prescription printouts, faxing and other admin tasks. I am happy to receive invoices related to these costs.</p>				
<b>CONSENT TO USE PATIENT INFORMATION</b>				
<p>Furthermore I understand that Doctor Aged Care and associated health care providers 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 Doctor Aged Care 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 and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Doctor Aged Care to use and disclose my personal information (except when legal obligations must be met).</p>				
_____ <i>Patient / Legal guardian signature</i>			_____ <i>Date</i>	