



**[Name & Logo of RACF]
MEDICAL & NURSING ADMISSION FORM**

Personal Details			
Name:	Preferred Name:	MRN:	
Date of Admission:	Admitted from:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Permanent admission <input type="checkbox"/> - Room No.	Respite admission <input type="checkbox"/> - Date of discharge / /		
Last Fixed Address:			
Marital Status: M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/>	Spouse/Partner:		
Date of Birth:	Medicare No.	Expiry Date:	
Country of Birth:	Pension No.	DVA No.	Colour:
Religion:	Attend church <input type="checkbox"/> Chaplain visits <input type="checkbox"/>		
Language Spoken:	Interpreter Required: No <input type="checkbox"/> Yes <input type="checkbox"/>		
Private Health Insurance: No <input type="checkbox"/> Yes <input type="checkbox"/>	Health Fund Name & No:		
Electoral Roll Status: Active <input type="checkbox"/>	Inactive <input type="checkbox"/>		
Nominated Medical Practitioner			
Dr.	Ph:	Fax:	AH:
Address:			
Emergency Contacts / Person Responsible			
Name:	Relationship:		
Address:	Ph:	(H)	(W) (M)
Name:	Relationship:		
Address:	Ph:	(H)	(W) (M)
Guardian / Power of Attorney (POA)			
Guardian <input type="checkbox"/> POA <input type="checkbox"/> - Enduring <input type="checkbox"/>	Name:		Relationship:
Address:	Ph:	(H)	(W) (M)
Financial Management			
Self <input type="checkbox"/> Other <input type="checkbox"/> - Name:	Relationship:		
Address:	Ph:	(H)	(W) (M)
Funeral Arrangements			
Funeral Parlour:	Address:		Ph:
Burial <input type="checkbox"/> Cremation <input type="checkbox"/>	Special Instructions:		
NURSING ASSESSMENT			
Diagnosis:			
Allergies / Reactions:			
BP	P	T	R
Weight:	kg	Height:	cm
BSL	Urinalysis:	Medications available <input type="checkbox"/>	Scripts available <input type="checkbox"/>
Speech/Communication			
normal <input type="checkbox"/>	unintelligible <input type="checkbox"/>	unable to construct whole sentences <input type="checkbox"/>	repeats single sound/word <input type="checkbox"/>
expressive impairment <input type="checkbox"/>	receptive impairment <input type="checkbox"/>	follows directions <input type="checkbox"/>	responds to non-verbals <input type="checkbox"/>
Sensory			
Eyes:	bright <input type="checkbox"/>	dull <input type="checkbox"/>	sunken <input type="checkbox"/> inflamed <input type="checkbox"/> discharge <input type="checkbox"/>
	equal <input type="checkbox"/> - right <input type="checkbox"/> left <input type="checkbox"/>	react to light <input type="checkbox"/> - right <input type="checkbox"/> left <input type="checkbox"/>	

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Sensory	
Eyelids: normal <input type="checkbox"/>	inwards <input type="checkbox"/> outwards <input type="checkbox"/>
Vision: normal <input type="checkbox"/>	impaired <input type="checkbox"/> Aid/s: glasses <input type="checkbox"/> artificial eye <input type="checkbox"/> Labelled - no <input type="checkbox"/> yes <input type="checkbox"/>
Hearing: normal <input type="checkbox"/>	impaired <input type="checkbox"/> Aid/s: right <input type="checkbox"/> left <input type="checkbox"/> Labelled - no <input type="checkbox"/> yes <input type="checkbox"/>
Mobility / Transfers	
Gait:	shuffling <input type="checkbox"/> balanced <input type="checkbox"/> paces floor <input type="checkbox"/> chairbound <input type="checkbox"/>
Mobility:	independent <input type="checkbox"/> chair bound <input type="checkbox"/> bed bound <input type="checkbox"/> requires assistance <input type="checkbox"/> - some <input type="checkbox"/> major <input type="checkbox"/> extensive <input type="checkbox"/> - No. of staff required
Aids used:	walking stick/s <input type="checkbox"/> frame <input type="checkbox"/> wheelchair <input type="checkbox"/> prosthesis <input type="checkbox"/>
Transfers:	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - No. of staff required
Aids used:	slide sheet <input type="checkbox"/> transfer belt <input type="checkbox"/> lifter <input type="checkbox"/> - type:
Falls	
History of falls no <input type="checkbox"/> yes <input type="checkbox"/>	Frequency:
Contributing factors:	
Safety requirements:	
Dietary Needs	
Diet: normal <input type="checkbox"/>	diabetic <input type="checkbox"/> salt reduced <input type="checkbox"/> lactose free <input type="checkbox"/> enteral <input type="checkbox"/> cut-up <input type="checkbox"/> minced <input type="checkbox"/> puree <input type="checkbox"/>
Likes:	Dislikes:
Fluids: thin <input type="checkbox"/>	thickened <input type="checkbox"/> - stage 1 <input type="checkbox"/> stage 2 <input type="checkbox"/>
Food allergies: no <input type="checkbox"/> yes <input type="checkbox"/> Reaction:
Feeding: independent <input type="checkbox"/>	requires assistance <input type="checkbox"/> - some <input type="checkbox"/> major <input type="checkbox"/> extensive <input type="checkbox"/> equipment used:
enteral <input type="checkbox"/> - type regime	
Skin (tick appropriate observation/s)	
Colour: pale <input type="checkbox"/>	cyanotic <input type="checkbox"/> jaundice <input type="checkbox"/>
Touch: warm <input type="checkbox"/>	cold <input type="checkbox"/> clammy <input type="checkbox"/>
Scalp: clean <input type="checkbox"/>	dandruff <input type="checkbox"/> sores <input type="checkbox"/>
Nails: pink <input type="checkbox"/>	pale <input type="checkbox"/> cyanotic <input type="checkbox"/>
Feet: intact <input type="checkbox"/>	broken <input type="checkbox"/> swelling <input type="checkbox"/>
Buttocks: intact <input type="checkbox"/>	broken <input type="checkbox"/>
On body indicate reddened areas, rashes, bruises, wounds, skin tears, scars and amputations.	
<div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> <p>Frontal</p>  </div> <div style="text-align: center;"> <p>Posterior</p>  </div> </div>	
Personal Care	
Preference: shower <input type="checkbox"/>	bath <input type="checkbox"/> sponge <input type="checkbox"/>
Frequency:	Time: am <input type="checkbox"/> pm <input type="checkbox"/>
Level of Assistance: independent <input type="checkbox"/> some <input type="checkbox"/> major <input type="checkbox"/> extensive <input type="checkbox"/> No. of staff required	

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Oral Care	
Mouth:	clean <input type="checkbox"/> moist <input type="checkbox"/> coated <input type="checkbox"/> ulcerated <input type="checkbox"/>
Teeth:	own - upper <input type="checkbox"/> lower <input type="checkbox"/>
Denture s:	Partial - upper <input type="checkbox"/> lower <input type="checkbox"/> Full - upper <input type="checkbox"/> lower <input type="checkbox"/> Labelled - No <input type="checkbox"/> Yes <input type="checkbox"/>
Toileting	
independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - some <input type="checkbox"/> major <input type="checkbox"/> extensive <input type="checkbox"/> No. of staff required	
Continence	
Bladder:	continent <input type="checkbox"/> incontinent <input type="checkbox"/> frequency <input type="checkbox"/> urgency <input type="checkbox"/> stress <input type="checkbox"/> nocturia <input type="checkbox"/> ileostomy <input type="checkbox"/> IDC <input type="checkbox"/> SPC <input type="checkbox"/> date inserted: size type Aids used: Requires support <input type="checkbox"/> - some <input type="checkbox"/> major <input type="checkbox"/> extensive <input type="checkbox"/>
Bowels:	continent <input type="checkbox"/> incontinent <input type="checkbox"/> haemorrhoids <input type="checkbox"/> colostomy <input type="checkbox"/> usual pattern last opened Hx constipation/diarrhoea <input type="checkbox"/> - usual management
Neurological / Behaviour	
Mood:	normal <input type="checkbox"/> agitated <input type="checkbox"/> flat <input type="checkbox"/>
Memory:	normal <input type="checkbox"/> short term problems <input type="checkbox"/> Mini Mental Score (MMSE):
Behaviours:	cooperative <input type="checkbox"/> resistive to care <input type="checkbox"/> repetitive actions <input type="checkbox"/> other <input type="checkbox"/>
Wandering/intrusive:	nil <input type="checkbox"/> occasionally <input type="checkbox"/> weekly <input type="checkbox"/> daily <input type="checkbox"/>
Triggers:	
Usual management:	
Verbally disruptive:	nil <input type="checkbox"/> occasionally <input type="checkbox"/> weekly <input type="checkbox"/> daily <input type="checkbox"/>
Triggers:	
Usual management:	
Physically aggressive:	nil <input type="checkbox"/> occasionally <input type="checkbox"/> weekly <input type="checkbox"/> daily <input type="checkbox"/>
Triggers:	
Usual management:	
Pain	
Location:	Location:
Cause:	Cause:
Frequency:	Frequency:
Relief measures:	Relief measures:
Sleep	
Usual routine:	Wakes & wanders <input type="checkbox"/>
Social History	
Smoker	No <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Yes <input type="checkbox"/> Years smoked Amount/day
Alcohol	No <input type="checkbox"/> Yes <input type="checkbox"/> Standard drinks/day
Advance Care Directives / Advance Care Plans	
Does the patient have an advanced care directive? Yes <input type="checkbox"/> - (obtain copy) No <input type="checkbox"/> - Do they want one? <input type="checkbox"/>	
In the event of a cardiac arrest does the patient want to be resuscitated? No <input type="checkbox"/> Yes <input type="checkbox"/>	
The above has been discussed with: Resident <input type="checkbox"/> Person responsible <input type="checkbox"/> Enduring Guardian <input type="checkbox"/>	
Admission completed by:	Designation: Date:

