KOOWEERUP REGIONAL HEALTH SERVICE

Expression of Interest

For Permanent Residential Care

P.O. Box 53, Kooweerup Vic 3981 Ph: 59 979 679 Fax: 59 971 248

Email: info@krhs.net.au Website: www.kooweeruphospital.net.au

Date Completed: / / Priority: ☐ Urgent ☐ Semi Urgent ☐ Future

A.	**APPLICANTS DETAILS**	
	Surname:	Given Names:
	Preferred Name:	☐ Male ☐ Female ☐ Other
	How do you prefer to be addressed:	e.g. Mr Smith or George
	Home Address:	
		Postcode
	Telephone Number:	Current Location:
	Date of Birth:	Age: Country of Birth:
	Are you of Aboriginal and/or Torres Strait Islander origin? Aboriginal? ☐ Torres Strait Islander? ☐ Aboriginal & Torres Strait Islander? ☐ Not Aboriginal or Torres Strait Islander? ☐ Primary Language Spoken:	
	Marital Status:	☐ Married ☐ DeFacto ☐ Single ☐ Windowed ☐ Divorced ☐ Separated
	Do you have any specific cultural requirements?	
	Religion (optional):	
	Do you have a current ACAT/ACCR/NSAF completed? **Copy to be attached**	☐ Yes ☐ No
	Referral Code:	
	Do you have an Enduring Power of Attorney? **Copy will be required on admission**	☐ Yes ☐ No
	Do you have an Advance Health Directive? **Copy will be required on admission**	☐ Yes ☐ No
B.	**MEDICARE/PENSION/HEALTH INSURANCE**	
	Name on Medicare Card:	
	Medicare Number:	ID: Expiry Date: / /
	Are you in a Health Fund? ☐ Yes ☐ No	Member No:
	Do you hold an Australian Pension Card?	☐ Yes ☐ No
	Do you hold a Centrelink Card?	☐ Yes ☐ No
	Do you hold a Department of Veterans Affairs Card?	☐ Yes ☐ No
	If yes, indicate type of Pension?	☐ Age ☐ Disability ☐ Widow ☐ Blind ☐ Overseas ☐ DVA ☐ Other
	Pension/DVA Card Number: ☐ Gold ☐ White	Expiry Date: / /
	☐ Full Pension ☐ Part Pension ☐ Self-Funded	
	Are you an Australian Ex-Prisoner of War?	☐ Yes ☐ No
	Ambulance Cover? ☐ Yes ☐ No	☐ Number:
	Diabetic Association Number:	
	Do you intend to remain on the Electoral Roll?	☐ Yes ☐ No

C.	**NOMINATED REPRESENTATIVE (received all correspondence and accounts)**
	Please tick if representative is primary contact: ☐
	Surname: Given Names:
	Home Address:
	Postcode:
	Telephone No. (daytime) Telephone No. (A/H)
	Mobile No.
	Email Address: Note your email address will be used to keep you and your family informed of facility information
	Drivers Licence Number:
	Relationship to Applicant:
	☐ Next of Kin ☐ Medical Enduring Power of Attorney ☐ Guardian ☐ Financial Enduring Power of Attorney
	☐ Joint Signatory ☐ Administrator ☐ Other: **Certified copies will be required on admission**
D.	**SECONDARY CONTACT**
	Please tick if representative is primary contact: ☐
	Surname: Given Names:
	Home Address:
	Postcode:
	Telephone No. (daytime) Telephone No. (A/H)
	Mobile No.
	Email Address: Note your email address will be used to keep you and your family informed of facility information
	Drivers Licence Number:
	Relationship to Applicant:
	☐ Next of Kin ☐ Medical Enduring Power of Attorney ☐ Guardian ☐ Financial Enduring Power of Attorney
	☐ Joint Signatory ☐ Administrator ☐ Other: **Certified copies will be required on admission**
E.	**OTHER DETAILS:**
F.	**MEDICAL DETAILS: (if you have a current detailed summary of your health, please attach a copy):**
	What is your current General Practitioner's name?
	Address:
	Postcode:
	Telephone No: Facsimile No:
	Mobile No:
	Who is your nominated Doctor on admission to the facility?
	G.P. Contact No:
	Have you had this year's Flu Injection? If yes: Month: Year:
G.	**FUNERAL ARRANGEMENTS:**
	Have prior funeral arrangements been made? ☐ Yes ☐ No
	Please indicate your wishes: Cremation ☐ Yes ☐ No Burial ☐ Yes ☐ No
	Please provide the name and address of the Funeral Director to be notified:
	Name:
	Address:
	Postcode: