



**Prospective Resident
Information Form**

Name: _____ Preferred Name: _____

Date of Birth: _____ Place of Birth: _____

Home Address: _____

How many years at this address: _____

Present Address: _____

A.C.A.T assessment date: _____ HIGH / LOW: _____

Person Responsible: _____

P.O.A: _____

Enduring Guardianship: _____

Husband / Wife: _____

Other Family Members: _____

Diagnosis / problems / special considerations:

_____ Weight: _____

Known allergies:

Vision: _____

Glasses: _____

Optometrist: _____

Hearing: _____

Aids: _____

Audiologist: _____

Dentures: _____

Dentist: _____

Verbal Communication: _____

Mobility: _____

Aids: _____

Physiotherapist: _____

Continence: _____ Bowels: _____

Mental State: _____



**Prospective Resident
Information Form**

Memory: _____

Behavioural Problems: _____

Wandering: _____

Assistance required with showering/washing/dressing: _____

Bath / Shower preference: _____

Pain: _____ Sleep Pattern: _____

Previous Interests: _____

Pets: _____ Interests Now: _____

Activities – capabilities now: _____

Food – special dietary requirements: _____

Allergies: _____

Food Preferences: _____

Assistance: _____

Cut up / Vitamised etc.: _____

Swallowing difficulties: _____

Podiatrist: _____ Hairdresser: _____

Belief Support: _____

Special Nursing Requirements: _____

Medication: _____ Assistance: _____

Pharmacist: _____

G.P: _____ Willing to attend FMH: _____

Other Medical Specialists: _____



**Prospective Resident
Information Form**

Other relevant information: _____

Reason for FMH application: _____

What is important to you, for us to provide for the prospective Resident: _____

Signed: _____

Relation to Prospective Resident: _____

Date Signed: ____/____/____