



XC200860

HEALTH SERVICE: _____	Surname	MRN	
RESIDENT ORIENTATION CHECKLIST (Residential Aged Care)	Given Name	DOB	Sex
	Address		Post Code
DOCTOR: _____			
Resident Preferred Name:	Room No:	Admission Date:	
GP Name:	Phone:		
Family / Representative/NOK Details:			
Name:		Relationship:	
Phone:	Mobile:	Email:	
Name:		Relationship:	
Phone:	Mobile:	Email:	
Name Enduring Power of Attorney : <input type="checkbox"/> Yes <input type="checkbox"/> No Guardianship: <input type="checkbox"/> Yes <input type="checkbox"/> No Phone:			
Medicare No:	Expiry Date:	Private Health Fund:	
Pension Card:	Veterans Card:		
Ambulance Fund:	Advance Health Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Advance Care Planning discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No			
RESIDENT ORIENTATION CHECKLIST			
<input type="checkbox"/> Welcome resident and family		<input type="checkbox"/> Create environment, private, comfortable	
<input type="checkbox"/> Explain a staff member is available 24 hrs		<input type="checkbox"/> Take resident / family on tour of service	
<input type="checkbox"/> Introduce resident to staff		<input type="checkbox"/> Explain about service routine re meal times / menus	
<input type="checkbox"/> Introduce resident to a few residents		<input type="checkbox"/> Laundry / electrical appliances	
<input type="checkbox"/> TV / Radio		<input type="checkbox"/> Provide mailing address and telephone number	
<input type="checkbox"/> Activities		<input type="checkbox"/> Provide a newsletter	
<input type="checkbox"/> Computer		<input type="checkbox"/> Explain compliments / complaint process	
<input type="checkbox"/> Photographs		<input type="checkbox"/> Give resident signed copy of Charter of Aged Care Rights	
<input type="checkbox"/> Valuables			
<input type="checkbox"/> Personal Phones			
<input type="checkbox"/> Call Bell (point out position)		<input type="checkbox"/> Explain Resident's Handbook	
<input type="checkbox"/> Fire alarm – what to do if they hear a fire alarm		<input type="checkbox"/> Talk to resident and their representative about the Resident Agreement, explain contents and that they may choose not to sign it.	
<input type="checkbox"/> Discuss WACHS Smoke Free Policy			
CONSENT TO THE RELEASE OF MEDICAL RECORDS			
I, _____ being patient / parent / carer / guardian hereby consent to the release of the health status / medical record information for _____ (patient's name) to relevant third parties who may become involved in the care, including but not limited to:			
<ul style="list-style-type: none"> • Referral to tertiary centre for ongoing clinical care (if required) • Referral to St John Ambulance and/or Royal Flying Doctor Service for transport services (if required) • Referrals to other health care provider for treatment, review and/or discharge planning (if required) 			
Signed:		Date:	
Staff Witness Signature:		Designation:	Date: