Weston Creek Family Medicine

Nursing Home Resident Information Form

We are committed to providing our patients with the best care.
To do this, it is essential that you complete the form with as much information as possible to ensure we have the most up to date and accurate health record for you.

Please tick Dr Mr Mrs Ms Miss	**Surname:**
Preferred Name:	**Give Names:**
Date of birth:………………………	**Sex:** Male Female Transgender

Marital status: Single Married De Facto Separated Divorced Widowed

Nationality and Religion: Aboriginal Torres Strait Islander Australian

Other *(Please specify):* ……………………………………………………………………………..

Cultural background:………………………………………….. Religion:…………………………..

Private Phone Number or Mobile:…………………………………………

Medicare Number: …………………………………………… *Ref*:………………… Expiry:……………

DVA Gold DVA White Card Number: ……………………………………………………

Pension Card Number: …………………………………………………… Expiry:……………………

Next of Kin and Enduring Power of Attorney

Primary Contact/ EPOA/Guardian:

Home: Mobile:

Person Responsible has Power of Attorney? YES NO Financial Medical

Secondary Contact:

Home: Mobile:

Nursing Home Residential Information

Name of Nursing Home:

Address:

Nursing Home Phone number: *Fax(if known):*

Nursing Wing: Patient Room Number:

Brief History

Do you have a current Geriatrician? Name……………………………………….
Phone………………………………………..

Have you see any of the following allied health professionals – please tick if applicable

Neurologist ▫	Rheumatologist ▫	Cardiologist ▫	Oncologist ▫
Endocrinologist ▫	Psychologist ▫	OPMH ▫	DBMAS ▫
Dietician ▫	Speech Pathologist ▫	Podiatrist ▫	Physiotherapist ▫

Other
………

Please provide a copy of your health summary and current medication list if available.?
Yes ▫ No
If not available a copy will be requested from your previous GP ?

Do you have an Advanced Care Plan in place? Yes No

Do you have funeral arrangements in place? Yes No

If yes, please provide nominated funeral director name and phone:……………………………………..
………

Are you for a Burial or Cremation

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Transfer of General Practitioner Care

Current General Practitioner

Name……………………… Practice name………………………………

Phone…………………..Fax………………………..

To ensure continuity of care, we will need to obtain a copy of your previous medical record. Please complete the "Patient's Signed Authority for Release/Transfer of Medical Records/Information form" attached.

Name of pharmacy used prior to nursing home entry/transfer)

Name ………………………Phone……………………..

Will you be remaining with this pharmacy or transferring you medication to the nominates Nursing home pharmacy? …………….

As part of our introduction to our service and the continuity of care, we will arrange an introduction consultation with you, your family member or support person and the GP.

For this first introduction consult are you able to attend the clinic with your family member or support person Yes ☐ No ☐

If no, we will contact you or your family member/support person and arrange an alternative arrangement at the Nursing Home.

Authority to transfer care to Weston Creek Family Medicine

By completing this form, you agree to the transfer your medical care to the General Practitioners of the Weston Creek Family Medicine

Dr Sudheer Gudipalli Dr Naoshaba Shafi Dr Ravi Ravulakollu

All information collected will be used to provide the best care possible, and your privacy will be respected at all times.

Please completed the form and sign that you have read and understand information and agree to using our service to provide your medical care.

Patient or EPOA: ………………………………………………………………… Date:

General Practitioner: ……………………………………..…………………… Date:

Nursing Home Care Manager *(if applicable)*: …………………………… Date:

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Patient's Signed Authority for Release/Transfer of Medical Records/Information

The patient below has elected to attend the Weston Creek Family Medicine for ongoing medical care. Would you please forward all medical information related to this patient.

To: ……………………..…………...……………………………………

………………..……
(Doctors or Practice Name and Address)

I ………………………………………………………………………… (Patients full name or EPOA)

Date of Birth:………………………………………………………

Formerly of ……………………………………………………………………………………
(Patient's former address)

Authorise the release of my medical records to be forwarded to;

Dr Sudheer Gudipalli / Dr Naoshaba Shafi /Dr Ravi Ravulakollu
WESTON CREEK FAMILY MEDICINE
Suite 1/16 Mahony Court , Weston ACT 2611
Ph: 02 6288 6008 – Fax: 02 6288 6723

Signed: ………………………………………………………… **Date:** ………………

To the Practice, please send;

Complete Medical Record
Health summary
Medication summary
Pathology results
X-Ray, Scans, etc
GPMP – 731/723/732
Health Assessment
Mental Health Plan 2710 & Review 2712

These records can be forwarded by;
Mail/ Fax/ Encrypted email (PKI)/ Non rewritable CD (HTML or XMLK version format)

Mailing Address: WESTON CREEK FAMILY MEDICINE
SUITE1, 16 MAHONY CRT
WESTON ACT 2611

FAX: 02 6288 6723 **Email:** reception@wcfm.com.au

Yours Sincerely.

Signed: ……………………………………………………… Date: ………………
Administration, Weston Creek Family Medicine