



# Peninsula Palms

Aged and Community Services

Telephone (07) 3897 2800  
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ACN 094 769 347  
ABN 68 094 769 347

Peninsula Palms  
Residential Care Facility  
PO Box 487 Redcliffe Q 4020  
77 Morris Road Rothwell Q 4022

## Medical Form

Applicant's Surname: ..... Date of Birth: .....

Given Names: .....

Address: .....

..... Post Code: .....

Are you the applicant's Doctor? Yes / No How long have you known the applicant? .....

### Current Medical Diagnosis:

•	•
•	•
•	•
•	•
•	•

**Allergies:** .....

Is there a diagnosis of Dementia? Yes / No Details: .....

Is there a diagnosis of Depression? Yes / No Details: .....

Special diet required? Yes / No Details: .....

**Medications / Treatments**

.	.
.	.
.	.
.	.
.	.
.	.
.	.

**Current Treating Specialists / Physicians**

Name: ..... Speciality: .....  
.....  
.....

**Medication Supervision** (please tick)

Unnecessary       Currently Provided       Recommended

**Alcohol Use?**      Yes / No      Comments: .....

**Smoking?**      Yes / No      Comments: .....

**Continence**

Urinary Incontinence      Yes / No      Comments: .....

Faecal Incontinence      Yes / No      Comments: .....

Troublesome Nocturia      Yes / No      Comments: .....

		Independent	Supervision	Physical Assistance
<b>Eating and Drinking</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Personal Hygiene</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mobility</b>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Transfers</b>	Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Aids used?**                      Yes / No

Please specify: .....

**Communication** (please tick)

Vision	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Hearing	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Hearing Aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Functional Speech	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Language Difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Social Interaction / Presentation**

Is there any evidence of:

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Social inappropriate behaviour | <input type="checkbox"/> Psychoses    |
| <input type="checkbox"/> Verbal aggression   | <input type="checkbox"/> Anxiety/Stress                 | <input type="checkbox"/> Confusion    |
| <input type="checkbox"/> Intrusive wandering | <input type="checkbox"/> Mental/behavioural disorders   | <input type="checkbox"/> Restlessness |

Comments: .....

.....

**Other Significant Information**

Please comment: .....

.....

.....

Dear Doctor,

Your patient is applying to become a resident in our Aged Care Facility. If they are successful will you be able to continue care of your patient, which would include visiting the facility (if resident is unwell), completing documentation required for funding and attending to medication reviews?

or

Would it be preferable for the resident to be admitted under one of our Doctors who attend to their rounds weekly at the facility?

Please discuss this matter with your patient.

Comments: .....

.....

.....

Doctor's Signature: ..... Date: .....

**Doctor's Details** (use stamp):