kalyra

Aged Care

Services Application

It's different here

Your (applicant) Information

First Name: ..... Middle ..... Last Name: .....

Preferred Name: ..... Mr / Mrs / Ms / Miss / Dr

Date of Birth: ..... ☐ Male ☐ Female ☐ Undisclosed

Address: .....

Suburb: ..... Postcode: .....

Home phone: ..... Mobile: .....

Preferred contact method: ..... Email: .....

Country of Birth: ..... Language spoken at home: .....

English Skills: ☐ Good ☐ Limited ☐ Interpreter Required

Are you hearing or sight impaired? .....

Religion / spirituality: .....

Indigenous Status: ☐ Non-Indigenous ☐ Aboriginal ☐ Torres Strait Islander

Home / financial / health care information

Accommodation ☐Own Home ☐ SAHT ☐ Private Rental

You live with ☐ Alone ☐ Spouse/Partner ☐ Family ☐ Other

Income source ☐ Aged Pension ☐ Private/Super ☐ DVA Gold/White ☐Disability Support Pension

NDIS Recipient ☐ Self Managed ☐ Plan Managed

Medicare Number ..... Pension number .....

Ambulance Number ..... Private Health cover .....

GP Name: ..... GP Clinic name: .....

GP Phone: ..... Pharmacy name: .....

Are you currently receiving any other care services? .....

.....

.....

Do You Smoke: Yes ☐ No ☐ .....

Vaccination Status

Fluvax ☐ COVID – AstraZeneca ☐ Pfizer ☐ Dose 1 ☐ Dose 2 ☐

Emergency Contact details

Emergency contact 1: ☐ Medical emergency ☐ Disaster event

Name: (Mr/Mrs/Ms)

Relationship to you:

English skills: ☐ Good ☐ Interpreter Required

Address:

Home/work Phone: Mobile phone:

Email:

Emergency contact 2: ☐ Medical emergency ☐ Disaster event

Name: (Mr/Mrs/Ms)

Relationship to you:

English skills: ☐ Good ☐ Interpreter Required

Address:

Home/work Phone: Mobile phone:

Email:

Your carer/advocate/decision making information

Do you have a: ☐ Carer ☐ Advocate *If yes, to either, please detail:*

Name: (Mr/Mrs/Ms)

Relationship to you:

English Skills: ☐ Good ☐ Interpreter Required

Preferred Phone:

Advocacy and decision making: Please indicate if you appointed an*:*

Enduring Power of Attorney ☐ No ☐ Yes *If yes, name:*

Medical Power of Attorney ☐ No ☐ Yes *If yes, name:*

Enduring Power of Guardianship ☐ No ☐ Yes *If yes, name:*

Phone number (if different from other contacts):

Other plans and decision making:

Do you have any of the following in place: **Statement of Choices (SOC), Good Palliative Care Plan (GPCP), Advance Care Plans, Anticipatory Direction (AntD)? If so, please provide details, and who holds copies?**

Would you like an information pack on Advance Directives? Yes / No

Health, Lifestyle and Interests (optional)

Please provide any additional information you feel is important:

Please describe any matters significant to you or recent changes. We will obtain further details from your Assessment**.**

Please describe your:

Social Interests	
Spiritual and cultural details	
Medical situation	
Physical concerns	
Psychological matters	
Any other details	

Other Kalyra Services:

If you would like information regarding other Kalyra Services, please indicate below:

Affordable Housing ☐

Help At Home ☐

Retirement Living ☐

How did you hear about us?

Radio ☐ Newspaper ☐ Mailbox Flyer ☐ Word of Mouth ☐

Trade show ☐ My Aged Care ☐ Hospital ☐ ACAT Team ☐

Private Placement Business ☐ Facebook ☐ Google Search ☐

Other ☐

If other, please describe: .....

.....

.....

.....

.....

Person completing this form:

Relationship to applicant:

Date service required from: **to *(if not ongoing)*:**

Date information collected:

Please Note:

- This form is for expression of interest only. Kalyra will aim to support you in accessing the service of your choice but does not guarantee the provision of service.
- The process for accessing service will vary depending on service required.
- Please phone our office on 8278 0300 for further information