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Admission paperwork

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Instructions for Completing Paperwork

Please complete the attached forms as soon as possible. Once we receive the Admission Paperwork forms, Financial Paperwork forms and a copy of the Aged Care Assessment, the applicant will be placed on the waiting list.

1. **Personal Details Form** (green form).
   The information on this form is used to record all personal details for the resident, i.e. Next of Kin, POA Details, Centrelink, Medicare and preferences for receiving accounts etc.
   Please provide copies of Power of Attorney documentation or Guardianship details if applicable.
2. **Financial Statement**
   Please complete these details with all information that is available. Please have the statutory declaration signed. Please attach any relevant documentation.
3. **Direct Debit Request**
   Please complete the form and return as soon as possible. This is our only method of payment of consumer accounts.
4. **Request for Laundry Labels**
   Please complete this form to have laundry labels printed for consumer's clothing. The costs will be charged to your first account.
5. **Donation Permission Form**
   Please sign this form if you are happy to donate $6 per month towards the social/cultural activities provided by this facility. This will be added to your monthly account.
6. **Resident Privacy Agreement**
   Please have Resident/POA/Guardian sign this form.
7. **Resident Consent Form**
   Please complete this form if Resident consents to photos and/or personal information being used in newsletters, iCare, medication charts, assessments etc.
8. **Permission for Transfer of Medical Information Transfer**
   This form allows us to request transfer of medical information from your current GP to our clinic - Lalor Clinic.
9. **Emergency Evacuation Plan**
   This form needs to be completed so in the event of an emergency, there is an evacuation plan in place.
10. **Policy for Medication and Herbal Remedies (including creams and lotions)**
    Please complete this form as acknowledgement of policies regarding medicines, herbal remedies and lotions stored in this facility.
11. **Residents Dietary Preferences**
    Please complete this form so that the kitchen is aware of the dietary requirement/ preferences and any food allergies.

Cont. PTO

Cont.

12. **Medication**

    Please have your GP complete and sign the Medication Chart supplied (unless they are coming from hospital).

    Bring your medications in a Webster Pack, it has to be a “single dose” Webster Pack not a “multi dose” pack.

13. **Advance Care Plan**

    Please complete this form to enable nurses to act according to your loved one’s wishes in the event of a medical emergency. This form also needs to be signed by the persons doctor as a witness to the document.

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Other Paperwork that is required before Admission

Centrelink - Compulsory

When entering an Aged Care Residential Facility, it is a requirement that you be assessed financially by the government.

A Pre-Assessment should be done by submitting a SA457 form (Permanent Residential Aged Care Request for a Combined Assets and Income Assessment). Once you receive your Pre-Assessment letter, it is valid for a period of 120 days.

If you enter care before a pre – assessment can be completed, you are still required to submit your forms to Centrelink as soon as possible. Until we receive notification from them you are liable to pay all accommodation payments. Failure to submit financials can also result in higher Means Tested Care Fees.

If you require further information, the following site: www.myagedcare.gov.au may be of assistance. Alternatively, you can contact them by phoning: **1800 200 422**. It may also be beneficial to seek help from a financial advisor who can give you advice on all your options available regarding payment of residential aged care costs.

Medical Information

Please ask your GP to print out a complete medical history including medications and dosages, surgical history etc.

A Resident Handbook has also been provided to you for further information about our facility.

We acknowledge the traditional custodians of this land, the Wurundjeri people, and pay our respects to the elders both past and present.

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RISPONDETE A TUTTE LE DOMANDE
ALL QUESTIONS MUST BE FULLY ANSWERED

COME HAI SENTITO PARLARE DI SAN CARLO?
HOW DID YOU HEAR ABOUT SAN CARLO? _____

PARTICULARS RELATING TO PERSON SEEKING ADMISSION

NOME
FULL NAME (BLOCK LETTERS) _____ NOME PREFERITO **PREFERRED NAME** _____

IO SONO (CERCHIA LA RISPOSTA / LE RISPOSTE) **I DESCRIBE MYSELF AS: (Please circle appropriate answer)** UN'UOMO **MALE** UNA DONNA **FEMALE** ETEROSESSUALE **HETEROSEXUAL**

OMOSESSUALE **LESBIAN GAY** BISESSUALE **BISEXUAL** TRANSESSUALE **TRANSGENDER** INTERSESSUALE **INTERSEX** PREFERISCO NON DIRE **PREFER NOT TO** SAY

INDIRIZZO
PRESENTADDRESS _____

NUMERO DEL TELEFONO – LAVORO
PHONE NUMBERS – BUSINESS/MOBILE _____ CASA **PRIVATE** _____

DATA DI NASCITA
AGE AND DATE OF BIRTH _____ DATA DELL'ARRIVO IN AUSTRALIA **DATE OF ARRIVAL IN AUSTRALIA** _____

LUOGO DI NASCITA
BIRTHPLACE _____ AVETE LA CITTADINANZA AUSTRALIANA? **ARE YOU A NATURALISED CITIZEN?** _____

RELIGIONE
RELIGION _____ SPOSATO, SINGOLO, VEDOVA, DIVORATO O SEPARATO **MARRIED, SINGLE, WIDOWED, DIVORCED/SEPARATED** _____

QUALE LINGUA PREFERISCI
WHAT IS YOUR PREFERRED LANGUAGE _____

NOMI ED INDIRIZZI DEI PARENTI STRETTI:
NAMES AND ADDRESS OF NEAR RELATIVES:

NOME **FULL NAMES**	INDIRIZZO **ADDRESS**	PARENTELA **RELATIONSHIP**	POA YES/NO **POWER OF ATTORNEY**	NUMERO TELEFONICO **PHONE NO.**

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FIGLI – **CHILDREN**

NOME E COGNOME **NAME IN FULL**	INDIRIZZO **ADDRESS**	EMAIL **EMAIL**	NUMERO TELEFONICO **PHONE NOS.**
1.			
2.			
3.			
4.			

I'INDIRIZZO EMAIL:
EMAIL ADDRESS: _____

PER RICEVERE FATTURE / NEWSLETTERE / ALTRE INFORMAZIONI
TO RECEIVE INVOICES / NEWSLETTER / OTHER INFORMATION

PERSONA RESPONSABILE DEGLI AFFARI FINANZIARII DEL CANDIDATO
PERSON/S RESPONSIBLE FOR HANDLING APPLICANT'S FINANCIAL AFFAIRS _____

ESISTE UNA DELEGA O QUALCHE FORMA DI PROCURA LEGALE? (FORNIRE I DETTAGLI)
HAS ANYONE RECEIVED AN EDURING POWER OF ATTORNEY AND/OR GUARDIANSHIP OR ADMINISTRATION POWER? (give details)

NUMERO DELLA PENSIONE
AUSTRALIAN PENSION No. _____

NUMERO ASSICURAZIONE MEDICA
MEDICARE No. _____
VALIDO PER:
VALID TO:____/_____

PHARMACY SAFETY NET NUMBER _____

CURRENT PHARMACY _____

DO YOU HAVE A HOMECARE PACKAGE? Yes / No

IF YES, COMMENCEMENT DATE ___/___/_____

DO YOU RECEIVE CAPS FUNDING Yes / No

ASSICURAZIONE PRIVATA MEDICO/OSPEDALIERA
PRIVATE HEALTH INSURANCE (Nome) _____ No _____

NUMERO SERVIZIO AMBULANZA
AMBULANCE No. _____

SOFFRI' DI' DIFFICOLTA SENSIORIALI (PERDITA DELL'UDITO, PERDITA DELLA VISTA, DIFFICOLTA NEL PARLARE, DIFFICOLTA NELL' INGHIOTTIRE, DIFFICOLTA NEL MANTENERE L'EQUILIBRIO)
DO YOU SUFFER FROM ANY SENSORY IMPAIRMENT i.e. Hearing loss/ vision loss / speech impairment / balance disorders?

IN CASO DI MORTE INDICATE LA DITTA DI POMPE FENEBRI PREFERITA.
IN THE EVENT OF DEATH, PLEASE STATE PREFERRED FUNERAL AGENCY. _____

Resident Privacy Agreement Consent Form

This form is consent to collect, use and disclose personal information of Residents/clients for the purpose of providing residential aged care.

The Australian Privacy Principles (APP), as set out in the *Privacy Act 1988* (Cth) and the *Privacy Amendment (enhancing Privacy Protection) Act 2012* (Cth).

In order that our establishments as Health Care Providers can provide you with the quality care/services outlined in your agreement with us, we collect from you or your designated representative, particular details.

We will use all reasonable efforts to protect the privacy of individuals' personal information and to comply with the obligations imposed by the *Privacy Act 1988* (Cth) (**Privacy Act**), the Australian Privacy Principles (**APP**), the Aged Care Act and the Aged Care Principles.

This policy applies to all staff (including contracted agency staff) and volunteers.
We will only collect personal information by lawful and fair means and will only collect personal information that is necessary for one or more of our organisation's functions or activities.

If it is reasonable and practicable to do so, we will collect personal information about an individual only from that individual.

In meeting our obligations with respect to the privacy of our clients we will acknowledge that people with vision or hearing impairments and those of culturally and linguistically diverse people may require special consideration.

Purpose of Policy

The purpose of this policy and procedure is to:

i) ensure personal information is managed in an open and transparent way;

ii) protect the privacy of personal information including Health Information of clients, Residents and staff;

iii) provide for the fair collection and handling of personal information;

iv) ensure that personal information we collect is used and disclosed for relevant purposes only;

v) regulate the access to and correction of personal information; and

ensure the confidentiality of personal information through appropriate storage and security.

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Resident Privacy Agreement Consent Form cont.

Use and disclosure of information

a) Permitted disclosure

We may not use or disclose Personal Information for a purpose other than the primary purpose of collection, unless:

i) the secondary purpose is related to the primary purpose (and if Sensitive Information directly related) and the individual would reasonably expect disclosure of the information for the secondary purpose;

ii) the individual has consented;

iii) the information is Health Information and the collection, use or disclosure is necessary for research, the compilation or analysis of statistics, relevant to public health or public safety, it is impractical to obtain consent, the use or disclosure is conducted within the privacy principles and guidelines and we reasonably believe that the recipient will not disclose the Health Information;

iv) we believe on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to an individual's life, health or safety or a serious threat to public health or public safety;

v) we have reason to suspect unlawful activity and use or disclose the Personal Information as part of our investigation of the matter or in reporting our concerns to relevant persons or authorities;

vi) we reasonably believe that the use or disclosure is reasonably necessary to allow an enforcement body to enforce laws, protect the public revenue, prevent seriously improper conduct or prepare or conduct legal proceedings; or

vii) the use or disclosure is otherwise required or authorised by law.

If we receive Personal Information from an individual that we have not solicited, we will, if it is lawful and reasonable to do so, destroy or de-identify the information as soon as practicable.

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Resident Privacy Agreement Consent Form cont.

b) Cross border disclosure

We will not disclose an individual's Personal Information to an overseas recipient. If we do, we will take all steps that are reasonable in the circumstances to ensure that the overseas recipient does not breach the Australian Privacy Principles, unless:

i) the overseas recipient is subject to laws similar to the Australian Privacy Principles and the individual has mechanisms to take action against the overseas recipient;

ii) we reasonably believe the disclosure is necessary or authorised by Australian Law; or

iii) the individual has provided express consent to the disclosure.

Some individuals may not want to provide information to us. The information we request is relevant to providing them with the care and services they need. If the individual chooses not to provide us with some or all of the information we request, we may not be able to provide them with the care and services they require.

Access

You have a right to request that we provide you access to the Personal Information we hold about you (and we shall make all reasonable attempts to grant that access) unless providing access:

i) is frivolous or vexatious;

ii) poses a serious threat to the life or health of any individual;

iii) unreasonably impacts upon the privacy of other individuals;

iv) jeopardises existing or anticipated legal proceedings;

v) prejudices negotiations between the individual and us;

vi) be unlawful or would be likely to prejudice an investigation of possible unlawful activity;

vii) an enforcement body performing a lawful security function asks us not to provide access to the information; or

viii) giving access would reveal information we hold about a commercially sensitive decision making process.

Requesting access

Requests for access to information can be made in writing and addressed to the Privacy Officer. We will respond to each request within 30 days.

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Resident Privacy Agreement Consent Form cont.

Grievance Procedure

How to make a complaint

If you wish to make a complaint about the way we have managed your Personal Information you may make that complaint verbally or in writing by setting out the details of your complaint to any of the following:

Our Privacy Officer or Delegate

Phone: 03 9404 1490

Fax: 03 9404 4390

Email: agnesl@sancarlo.com.au

Privacy Officer

We have appointed a Privacy Officer to manage and administer all matters relating to protecting the privacy of individual's Personal Information.
The Privacy Officer can be contacted if any relevant person wishes to obtain more information about any aspect of this policy or about the way in which we operate to protect the privacy of individual's Personal Information.

As stated above, complaints may also be made to the Privacy Office if any person suspects we have breached this Privacy Policy, the Australian Privacy Principles or they are otherwise unhappy with the management of their or if they are responsible for another person, that person's Personal Information.

Resident Name: _____ Date of Birth: _____

I , the under signed, understand that I have been provided with this Resident Privacy Agreement that explains all responsibilities as noted in the APP the Australian Privacy Principles (APP), as set out in the *Privacy Act 1988* (Cth) and the *Privacy Amendment (enhancing Privacy Protection) Act 2012* (Cth) and approve the collection and usage of my personal information including sensitive health information from all practical sources including my family, doctor and hospital and consent the collection and use of such information where necessary to meet my needs. I also acknowledge that a copy of my Agreement to Pay will be provided to any person guaranteeing and/or paying my accounts

Date: _____ /_____/_____

Name: _____ ☐ Resident ☐ POA/NOK (please tick one) Signature: _____	Witness Name: _____ Witness Signature: _____

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Permission for Medical Information to be faxed to San Carlo for our Doctors from Lalor Clinic (if using our doctors whilst residing San Carlo)

Applicant or Power of Attorney/Guardian to complete the details below:

Dear Dr.	(Your Current GP's Name)
Of:	(Clinic's Name)
	(Clinic's Address)
Ph:	(Clinic's Phone Number)
Fax:	(Clinic's Fax Number)

I (name of person requesting information) _____
request that the information regarding -

Title ____ First Name _____ Surname _____

D.O.B. _____

Address _____

Be forwarded to:

Dr Claude Baldi / Dr John Portelli (Lalor Clinic)
c/o San Carlo Homes for the Aged Ltd
970 Plenty Road South Morang, Vic 3752
or by Fax: 9404-4390
Email: sancarlo@sancarlo.com.au

☐ I am the applicant's Power of Attorney /Guardian /NOK ☐ I am the applicant
(Please attach a copy of POA/Guardianship)

Signature _____ _____ Date _____

Information required:

- Current Medical Surgical and Care Issues requiring interventions
- Past medical and surgical history
- Immunisation History
- Current medication regime
- Recent pathology and other tests as applicable

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Medication and Herbal Remedies Including Creams and Lotions

San Carlo Homes for the Aged respects the Resident rights to independence in both administrations of medications where safely possible and decision making in relation to care including medication use.

We are however obliged to ensure safe and appropriate administration and storage of medications. Residents requesting to self-administer will be formally assessed by medical staff as to their capacity to do so.

We therefore request Residents and families inform the facility of all medications in their possession and also inform us if they wish to have other items supplied or use other products. The medications can then be discussed with the treating GP and any interactions with prescribed medications addressed.

All medication items will need to be stored in a safe an appropriate manner which may be outside of a resident's own room. This includes over the counter products, creams, lotions and herbal remedies. Should medications be brought into the facility by the family or requested by Residents, we request the facility staff be informed.

I _____on

(Date)_____

HAVE READ THE ABOVE CONTENT AND AM AWARE OF THE FACILTY REQUEST.

Signature_____

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Request for Laundry Labels

As part of the laundry service and to help our staff to keep track of your clothing, it is a requirement upon entry to San Carlo Homes for the Aged Ltd that all items of clothing are labeled with the specific label designed for you. These labels can be provided on/or prior to admission. Extra labels may have to be purchased from time to time if new clothing is brought in.

Staff will attach labels to the clothing for a fee. $100 for 200 or $50 for 100 $25 for 50 (fee includes labels). These labels are heat sealed onto the clothing, the process does not harm the garment and the labels are printed by computer in indelible ink.

Name of Resident:				
Date of admission:				
Number of labels requested:	**200**	**100**	**50**	**(please circle)**
Applicable Fee:	**$100**	**$50**	**$25**	**(please circle)**
This fee will be invoiced to your Resident account				
Signature Authorising Request: _____ **Do you authorize additional labels to be invoiced to your resident account when for example new clothes are bought in and there are no more labels ☐ Yes ☐ No** **Signature Authorising Request: _____**				

(Office use)

Email for request of labels sent (date): _____

Resident/relative provided information regarding laundry: _____

Labels delivered and attached: _____

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Consent Form

For Use of Photos/And Or Personal Information

Permission for Resident's photo and/or personal information to be used by San Carlo for the purpose of Medication Charts, assessments, iCare Resident management program and newsletters etc.

Resident Name_____

POA/Guardian (if applicable)_____

Permission given: ☐ Yes ☐ No

Signed: _____ Date: ____/____/_____

Resident/Resident's POA/Guardian

Do you wish to have your name on your door?

Permission given: ☐ Yes ☐ No

Signed: _____ Date: ____/____/_____

Resident/Resident's POA/Guardian

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Emergency Evacuation Plan

To Whom It May Concern

As part of our Emergency Evacuation Plan, San Carlo Homes for The Aged is compiling individual Emergency Plans for each Resident. This will include a relocation place that each Resident will be taken to.

To assist us with this, could you please complete the information required below and return to San Carlo as soon as possible.

Residents Name: _____

If an emergency evacuation of San Carlo is required are you able to take Resident home?

Please tick answer:

Yes ☐ No ☐

- If Yes how long could you have Resident home for: _____
- Name of Person taking Resident home:_____
- Address/Telephone No. that Resident will be going home to:

  _____

  _____

  Telephone No: _____

Will you be able to pick Resident up from San Carlo?

Yes ☐ No ☐

If No, would you require San Carlo to organize transport i.e. Maxi Taxi.

Yes ☐ No ☐

If yes, please see Nurse in Charge of your loved ones unit to complete the Emergency Evacuation Care Plan.

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Advanced Care Plan

Name:	Date of Birth: / /
Date: / /	

PREFERENCES FOR MEDICAL CARE

Hospitalization: Do you prefer to be treated in the hospital rather than the aged care facility whenever possible?	☐ Yes ☐ No
Antibiotics: I want antibiotics to be used to treat infections?	☐ Yes ☐ No
Pain Management: Is effective pain management and comfort care a priority for you?	☐ Yes ☐ No
Pastoral Services: I wish to receive pastoral care services?	☐ Yes ☐ No
Palliative Care: I prefer to receive palliative care focused on comfort rather than curative treatment if I am nearing the end of life.	☐ Yes ☐ No

SPECIFIC MEDICAL INTERVENTIONS

Cardiopulmonary Resuscitation (CPR): I want CPR attempted if my heart stops.	☐ Yes ☐ No
Mechanical Ventilation: I want mechanical ventilation if I am unable to breathe on my own.	☐ Yes ☐ No
Artificial Nutrition and Hydration: I want artificial nutrition and hydration if I am unable to eat or drink on my own.	☐ Yes ☐ No
Dialysis: I want dialysis if my kidneys stop functioning.	☐ Yes ☐ No

ANY ADDITIONAL INFORMATION

MEDICAL DECISION-MAKER

Primary Decision-Maker (MTDM / POA / NOK) please circle**:**
Name:
Relationship:
Signature:
Alternate Decision-Maker (MTDM / POA / NOK) please circle**:**
Name:
Relationship:
Signature:
Competent Self:
Name:
Signature:

HEALTHCARE PROVIDER ACKNOWLEDGMENT

General Practitioner:
Name:
Signature:

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Resident's Dietary Preferences/Information

Name: Please circle what is appropriate

What are the resident's Special Dietary Needs?	Diabetic Diet / Vegetarian Diet / Dysphagia / Gluten Free / Lactose Free /
What Meal Type does the resident want?	Regular Diet / Easy to Chew Diet / Soft & Bite Sized Diet / Minced & Moist Diet / Pureed Diet / Cut Up
Does the resident want a meal type that may cause them problems?	
What meal size does the consumer want?	Small size meal / Medium size meal / Large size meal
What Fluids Type does the resident want?	Thin Fluids / Slightly Thick Fluids / Moderately Thick Fluids / Extremely Thick Fluids
Does the resident want a fluid type that may cause them problems?	
What are the resident Dietary Likes?	
What are the resident Dietary Dislikes?	
What assistance does the resident want?	
What aids does the resident want?	Normal Plate / Soup Plate / Small bowl / Plate Guard / Normal Tea Cup / Two Handled Mug / Special Cutlery / Normal Cutlery
Are there any cultural / religious dietary preferences, Please specify	
Does the resident have any Food allergies? If Yes Please specify Type and Reaction	
If the resident does have a food allergy has it been diagnosed by a doctor?	
If the resident does have a food allergy have you ever had an Anaphalactic reaction?	

Resident/POA/NOK Name: Signature:

Date: / /

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Visitor Code of Conduct 2.6A

Policy Level 2

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Contents

Purpose

To ensure a safe, respectful, and supportive environment for residents, staff, volunteers, and other visitors by outlining clear expectations for visitor behaviour while on San Carlo premises.

This policy supports San Carlo's commitment to upholding the dignity, rights, and wellbeing of all individuals within the facility and its broader environments, in alignment with our organisational values and legal obligations.

Scope

This policy applies to all visitors (excluding employed or contracted staff, agency personnel, and volunteers) who interact with San Carlo's workforce, residents, and/or environment—physically or electronically.

Definitions

Visitor

A visitor refers to any person (other than staff members, volunteers, and agency personnel) who interacts with San Carlo's workforce, residents, and/or environment. This includes (but is not limited to):

- Residents' families and friends.
- Contractors.
- Visiting health professionals; and
- Representatives of other organisations.

Premises

To this policy, 'premises includes the internal, external, physical, and electronic environment of San Carlo. For example, interactions on or within the premises could involve:

- Emails sent to the organisation or individual staff members.
- Phone or video calls made to the organisation; or
- Discussions held in-person anywhere on the facility grounds.

Work Related Violence

Work-related violence involves incidents in which a person is abused, threatened, or assaulted in circumstances relating to their work.

Policy Statement

San Carlo is committed to maintaining a clear, consistent, and accessible set of policies that support its mission, ensure compliance with applicable laws and regulations, and promote effective governance and operations.

Responsibilities

As an organisation San Carlo is committed to protecting the rights of all persons, including residents, employees, volunteers, and visitors. This includes the right to:

- Not be discriminated against based on culture, religion, sexual identity, values, and/or beliefs;
- Be treated with respect and dignity at all times;
- Experience physical and emotional safety at all times;
- Work in or visit an environment free of harassment and anti-social behaviour;
- Work in a professional and supportive environment; and
- Have personal privacy and confidentiality maintained.

San Carlo has specific legal, ethical and moral responsibilities to ensure these protections exist for all persons while on the premises. This includes, but is not limited to, our responsibilities under the Occupational *Health and Safety Act 2004*.

San Carlo does not tolerate violence perpetrated by visitors or any other persons.

Policy Awareness

This policy is available in the Admission Information Pack and on our website (www.sancarlo.com.au)

Visitor Responsibilities

Expected Behaviour

Whilst on or interacting within the premises, visitors are asked to:

- Engage respectfully and courteously with all persons and not behave in ways that may be considered harassing or offensive.
- Remain calm when managing personal frustrations to limit the impact on the work or care of others.
- Speak at a volume appropriate for the environment and circumstances and avoid shouting.
- Not use language directed at, or about, another individual that may be considered offensive or abusive in any culture. This includes the use of threats, expletives, profanities, and swearing in any language.
- Ensure written communication is courteous and polite.
- Avoid gestures that may be considered aggressive (such as eye rolling, sneering, and intimidating hand gestures).
- Refrain from any behaviour that may be considered physically intimidating (such as invading someone's personal space or standing over them).
- Refrain from any form of physical assault (such as biting, scratching, spitting, pushing, shoving, tripping, or grabbing another person)

- Respect the personal privacy of residents, staff, and other visitors. San Carlo employees cannot provide visitors with personal information regarding residents, employees, or other visitors without consent of the individuals concerned.
    - This includes refraining from capturing videos and photographs of residents or staff without their express permission. Visitors must note that unauthorised filming/photography in certain areas of the facility may be in breach of Australian privacy laws.
- Adhere to all organisational advice regarding visiting arrangements. Limitations San Carlo places on visiting may result from external regulatory requirements and are regularly reviewed in relation to current risks (such as active outbreaks of COVID-19 or influenza).
- Never attend the facility grounds when feeling unwell and/or knowingly infected with a condition that can be easily transmitted to others (such as influenza, COVID-19, gastroenteritis).
- Exercise tolerance and understanding of staff members' best efforts to provide care to all residents. The needs of our residents are prioritised, which may impact on service timeframes to visitors in some instances.

Nothing in this policy restricts the right of visitors to provide feedback or make a complaint about the care or services delivered by San Carlo. However, feedback should be delivered in ways that are keeping with this Visitor Code of Conduct.

Information our feedback and complaints policy is available in the Resident & Relative handbook, on the San Carlo website (www.sancarlo.com.au), and on request.

Responding to Breaches of Conduct

Employee Response

Employees who observe or are affected by visitor behaviour not in keeping with the expectations outlined in this policy should bring this to the attention of their relevant Manager and complete a Staff Incident Report.

The Chief Executive Officer (CEO) and Human Resources (HR) Manager should also be informed of such incidents so that they can be addressed as soon as possible.

Organizational Response

If a complaint is received from any persons regarding offensive, harassing or inappropriate behaviour of a visitor whilst on the premises, San Carlo will endeavour to contact the person(s) in writing, advising them of the concerns raised and bringing the requirements of this policy to their attention.

An offer to discuss the matter with the CEO or delegate will also be provided. This gesture is made in good faith with the wellbeing of residents, employees and other visitors as the highest priority.

In extreme circumstances where the behaviour continues and jeopardises the occupational health and safety of residents, employees, or other visitors, serious measures will be considered, including limiting access to San Carlo premises for the individual(s) concerned. If the behaviour persists, involvement of law enforcement and/or other legal avenues of redress may be pursued by the CEO.

Related Policies and Legislation

Policies and Procedures

- 1.2B Resident Privacy & Confidentiality
- 2.5A Occupational Violence and Aggression
- 2.6B Resident & Visitor Feedback
- 2.7A Employee & External Privacy Policy
- 2.2F Bullying & Harassment
- Code of Conduct and Ethics (for staff)

Legislation

- Equal Opportunity Act 2010 (Vic)
- Human Rights and Equal Opportunity Commission Act 1986 (Cth)
- Charter of Humans Rights and Responsibilities Act 2006 (Vic)
- Sex Discrimination Act 1984 (Cth)
- Racial and Religious Tolerance Act 2001 (Vic)
- Age Discrimination Act 2004 (Cth)
- Disability Discrimination Act 1992 (Cth)
- Workplace Gender Equality Act 2012 (Cth)
- Occupational Health and Safety Regulations 2007 (Vic)
- Occupational Health and Safety Act 2004 (Vic)
- Surveillance Devices Act 1999 (Vic)
- Privacy Act 1988 (Cth)

Document Version Control and Review History

Version	Date	Changes	Approval	Next Review
1.0	July 2022	All	Chief Executive Officer	June 2024
1.1	Dec 2022	Expected Behaviour	Chief Executive Officer	Nov 2024
1.2	May 2023	All	Chief Executive Officer	Jan 2025
1.3	Feb 2024	Dates	Chief Executive Officer	Feb 2027
2.0	July 2025	All	Chief Executive Officer	July 2028

Authority

This policy is authorised under delegation by:

Ron Hooton

Chief Executive Officer (CEO)

_____POA / NOK agree to abide by the above San Carlo's Visitor Code of Conduct.

(Print Name)

Signature: _____ Date:_ _ _ _/ _ _ /_ _ _ _

UNCONTROLLED DOCUMENT WHEN PRINTED

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LEISURE AND LIFESTYLE RESIDENT CONSENT FORM

Resident Name: _____ D.O.B: _____

Resident and/or POA/NOK permission to...

For staff to lock resident's room on their behalf when resident is not inside? ☐ Yes ☐ No

If no, on a Dementia Unit do you understand that another resident could intrude into your room when unattended and left unlocked. ☐ Yes ☐ No

A small facility kiosk is available for residents to purchase items of convenience. Do you wish to utilise this service and agree that purchases will be paid in cash or added to the monthly account? ☐ Yes ☐ No

Would you like to attend the Hairdresser (Spoleto Design) who attends the facility on Thursdays and do you agree to paying for the service as an extra cost on the account? ☐ Yes ☐ No

Beauty Therapy, where possible is provided by the leisure team. **Please give details of any beauty requests** like Nail Painting (inc. preferred colours?), Hair Removal (inc. preferred method) and/or Pamper Sessions?

Resident Name and Photo Use Permission:

I understand that during the time that I/the resident resides at San Carlo Homes for the Aged, my/their name and/or photo may be printed and placed in general areas that other residents, families and staff will be able to see (i.e. bedroom doors, noticeboards, displays in unit/reception areas). Initial: _____

I understand that my/their name and/or photo may be used in newsletters and on the Centrim Application for the purpose of communication between staff and residents/representatives, and that these avenues are meant for the San Carlo Community including Residents, Families and Staff of San Carlo HFTA Initial: _____

I understand that San Carlo HFTA has a duty of care in regards to my/their privacy and dignity and that use of names and/or photos in any form outside of these internal means of communication will be discussed with me/my representative prior to being used. Initial: _____

Resident consent for bus trips: ☐ Yes ☐ No

I give permission for (Name)_____ to be included in selected outings to community venues

I understand that I/they will be transported on a facility bus, but in case of any issue (i.e. bus breakdown, resident wish to return prior to outing completion) a taxi (or maxi taxi) will be the replacement form of transport, and there may be a cost associated with this. ☐ Yes ☐ No Initial: _____

I understand that there may be an amount (cost) associated with the outing and that that amount will be on charged to the next monthly account total. ☐ Yes ☐ No Initial: _____

POA/NOK wishes to be contacted before resident goes on an outing ☐ Yes ☐ No

USE OF CENTRIM APPLICATION

I understand that the use of the Centrim Application is for communication between staff and families. I, the POA/NOK/Resident understand that I am only to send access for the Centrim Application, to immediate family members (Spouse and/or Children of Resident) or nominated representative/s, and that the information accessed on the Application is not to be reproduced in any way. Initial: _____

POA/NOK: (Print Name)_____ Signature: _____ Date: ___/___/_____

Lifestyle (Print Name): _____ Signature: _____

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HOMES FOR THE AGED

About me | Snapshot

Name:

Please call me:

I was born in:

I am most proud of: Social & Personal History

A good day for me includes: Likes, dislikes, wishes/ hopes & fears

Please talk or engage with me about: Hobbies,Pastimes & Interest/ Relatives /friends

I feel relaxed and comfortable when: What I expect from aged care & staff

NOTE: as much as possible, this should be written from the individual's perspective.

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DIRECT DEBIT REQUEST FORM (DDR)

I / We request you, San Carlo Homes for the Aged Ltd ABN 57 131 178 759 (User ID 408347), to debit funds from my / our nominated account at the financial institution shown below according to the details specified.

YOUR DETAILS

Name(s)	
Address	
	Postcode
Telephone	Home Work

DETAILS OF YOUR BANK ACCOUNT

Account Holder	
Name and Branch of Financial Institution where account is held	
BSB No.	-
Account Number	

DETAILS OF THE AMOUNT TO BE DEBITED

Commencing on ..... you are authorised to debit a maximum of (the full amount of account) from the above account on the 15th day of each month.

YOUR AUTHORISATION

Signature(s) ....

If debiting from a joint bank account, all signatures may be required

Date

DIRECT DEBIT

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

INFORMATION STATEMENT

The Residential Medication Management Review (RMMR) is a service referred by a Medical Professional who confirms that there is an identifiable clinical need for the Patient to have the service, and it is provided to residents living in approved Australian Government funded Aged Care Facilities. Credentialed pharmacists visit residents in facilities to conduct a comprehensive review of the resident's medication to identify, resolve and prevent medication related problems.

In order to receive the RMMR service **you need to be a Medicare and/or Department of Veterans' Affairs** (DVA) cardholder, currently experiencing, or at risk of experiencing, medication misadventure, have received a referral from a Medical Professional and:

- a permanent resident of an Australian Government funded Aged Care Facility; or
- a permanent resident in a facility receiving funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care program; or
- a permanent resident of an MPS facility; or
- a resident in an Australian Government-funded Transition Care Facility for more than 14 consecutive days

Under this service, your pharmacist will:

- Assess your eligibility to receive the service and obtain informed consent from you
- Review your prescription medications, over the counter medications, vitamins or supplements
- Talk to you about your medical conditions and any allergies you may have
- Send a written report stating their findings and outline recommendations to relevant members of your healthcare team
- If necessary, conduct any follow up service(s)
- Upload a record of the RMMR service to your My Health Record (if you have one)
- Collect personal and sensitive information from you to enable the pharmacist to claim a payment for delivery of this service.

The Australian Government is paying the Service Provider for the RMMR Service. You will not be charged a fee by the Service Provider, however, if you do not meet the Eligibility Criteria or do not consent to your information being provided to the PPA and Department of Health and Aged Care for the purpose of claiming a funded service, the Service Provider may offer the service at your own cost.

You will still be required to pay the costs of the medicines that will be checked through this RMMR service including the PBS co-payment (if applicable) when medications are dispensed.

This program is funded by the Australian Government.

WHAT YOU NEED TO KNOW BEFORE YOU GIVE CONSENT

This consent form is to allow the pharmacist to provide your personal information to the Pharmacy Programs Administrator (PPA) and the Department of Health and Aged Care to verify your eligibility to receive the RMMR service and to enable the pharmacist to claim a payment for providing this service.

If you choose to provide written consent, the pharmacist will require you to sign the Written Consent form on page 3. If you are unable to provide written consent, your pharmacist will obtain verbal consent and keep a record by filling in the Verbal Consent form on page 4. If you are unable to provide consent the pharmacist will fill out the Unable to Provide Consent form on page 5.

This process is similar to the clinic/GP practice providing your Medicare number to claim for you seeing a Health Worker or General Practitioner (GP). Your personal information is protected by law, including the Privacy Act 1988. The Department is unlikely to disclose your personal information to overseas recipients.

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

Your/the patient's personal information that will be collected by the pharmacy include:

- Personal details – Name, Address, Medicare number, Date of Birth
- The names of the medicines you/the patient are taking; and
- Details about the patient's authorised representative, if applicable.

If you do not provide your consent to the collection of information for this purpose, your pharmacist will not be able to assess your eligibility for the service and you will not be able to access a funded RMMR service. In this event, you may be required to pay for the cost of the service to your pharmacist.

The Department has a privacy policy which you can read at: http://www.health.gov.au/privacy. The Department can be contacted by telephone on **(02) 6289 1555** or free call **1800 020 103** or by using the online enquiries form at http://www.health.gov.au.

The Pharmacy Programs Administrator has a Privacy Policy you can read here: https://www.ppaonline.com.au/privacy-policy. The Pharmacy Programs Administrator can be contacted by telephone on **1800 951 285** or email at support@ppaonline.com.au.

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

SERVICE DETAILS *Must be filled in by the pharmacist prior to service.

Name of Pharmacist Providing Service	Andriana Vamvakinos	**Date of Service**	
Patient Name (Given name and family name)			

WRITTEN PATIENT CONSENT

Consent provided by the patient:

I acknowledge I have read or had explained to me, and understand, the contents of the RMMR Service Information Statement.

By signing below, I consent to receive the RMMR Service and to the collection of my personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Patient Signature		**Date of Consent**	

Consent provided by a person authorised to act on behalf of the patient:

This may be filled in by the patient / individual who has the legal authority to consent and sign on the **patient's behalf (for example, a guardian, a person appointed under an enduring power of attorney or a** person otherwise authorised to give this consent in your State or Territory).

If you are signing on behalf of the patient, please indicate your relationship to the patient:

- ☐ Parent or guardian of child
- ☐ Enduring Guardian, recognised by a relevant state or territory law
- ☐ Enduring Power of Attorney, recognised by a relevant state or territory law
- ☐ A person who has been nominated in writing by the patient while the patient was capable of giving consent
- ☐ A person recognised by a relevant state or territory law

By signing below, I consent to the patient receiving the RMMR Service and to the collection of their personal information by the Pharmacy Programs Administrator and the Australian Government Department of Health and Aged Care to enable the pharmacy to claim a payment for delivery of that service and for program monitoring and evaluation purposes.

Authorised Person Signature		**Date of Consent**	
Authorised Person Name			

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

SERVICE DETAILS *Must be filled in by the pharmacist prior to service.

Name of Pharmacist Providing Service	Andriana Vamvakinos	**Date of Service**	
Patient Name (Given name and family name)			

VERBAL CONSENT (BY AUTHORISED LEGAL REPRESENTATIVE)

In some instances where consent must be obtained from an individual who has the legal authority to do so **on the patient's behalf** (such as a guardian, a person appointed under an enduring power of attorney or otherwise authorised to give this consent in your State or Territory), it is acknowledged that written consent may be difficult to obtain.

In these scenarios, where provision of the RMMR service is at risk of being delayed, verbal consent may instead be obtained from the legal representative.

A patient's personal details must NOT be passed on by the Service Provider if verbal or written consent has not been obtained for this to occur.

To be completed by the person obtaining verbal consent:

☐ I have explained to the **patient's authorised legal representative** how the information will be used for the purpose of conducting a RMMR Service as funded by the Australian Government

☐ The **patient's authorised legal representative** has verbally provided consent for the Service **Provider to collect and disclose the patient's personal information to the PPA, the Department, the Patient's Community Pharmacy and, if required, other Service Providers for the purpose indicated** above.

Please indicate who provided the consent:

Authorised Person Name (Given name and family name)		**Date of verbal consent**	
Authorised Person's Address			

Please indicate the **authorised person's relationship with the patient:**

☐ Parent or guardian of child

☐ Enduring Guardian, recognised by a relevant state or territory law

☐ Enduring Power of Attorney, recognised by a relevant state or territory law

☐ A person who has been nominated in writing by the patient while the patient was capable of giving consent

☐ A person recognised by a relevant state or territory law

Details of person who obtained the verbal consent:

Name of person who obtained verbal consent		**Name of Service Provider**	
Signature of person who obtained verbal consent			

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Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW (RMMR) INFORMATION AND CONSENT FORM

UNABLE TO OBTAIN PATIENT CONSENT

If the patient does not have the capacity to provide their consent, and there is no other suitable person who is able to provide consent on behalf of that patient, such as a guardian or a person appointed under an enduring power of attorney, a service can still be completed, where you consider that without completing a service:

- The **patient's physical or mental health or safety may be significantly and detrimentally** impacted;
- The patient may be exposed to a potentially life-threatening situation; and/or
- The patient might reasonably be exposed to serious injury or illness.

Your collection, use and disclosure of the patient's information under the RMMR program will be permitted under the *Privacy Act 1988 (Cth).*

If no Patient Consent (or other authorised person consent) is available please complete this section (including tick box):

☐ I, the Credentialed Pharmacist undertaking the service, confirm that the patient does not have the capacity to provide consent for this RMMR service to be undertaken and there is no suitable **person to give consent on the patient's behalf. Also in my opinion, without the service, the patient** is at risk of experiencing at least one of the three scenarios listed above.

Patient Name (Given name and family name)			
Name of Credentialed Pharmacist undertaking the service	Andriana Vamvakinos	**Date of Service**	
Name of Service Provider	Andriana Vamvakinos		

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Australian Government

my medicare

Registration Form

MyMedicare is a voluntary patient registration model. It aims to formalise the relationship between patients, their general practice, general practitioner (GP) and primary care teams.

MyMedicare patients and their usual GP and practice will have access to new benefits to help deliver more of the care patients need, improving health outcomes.

Patient Details

Family name

First given name

Second given name

Date of Birth

(dd) (mm) (yyyy)

Medicare Number or DVA File Number

Medicare IRN

Practice and Provider Details

Practice Name and Practice Address

LALOR CLINIC

1 MESSMATE ST, LALOR 3075 VIC

Name of Preferred GP Dr.

By signing this form I agree to the following:

I understand that registering in MyMedicare is voluntary.

1. I consider this Practice to be my regular primary health care provider.
2. I understand that I can only be registered with one Practice at a time. By submitting this form, any existing registration in MyMedicare will be withdrawn, and my previous Practice and provider will automatically be notified that I am no longer registered with them under MyMedicare.
3. I understand that I will remain registered unless:
   - I register with a different Practice.
   - I request my GP/Practice or Services Australia to withdraw my registration.
   - My GP or Practice decides to withdraw my registration.
4. I understand that there is no cost to register in MyMedicare.
5. I declare I have read and understand the MyMedicare Privacy Notice and consent to my personal information being collected, used and disclosed by the relevant agencies such as Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and, where applicable, the Department of Veterans' Affairs as specified in the MyMedicare Privacy Notice (a link to this notice is provided in the Privacy Statement at the bottom of this form).

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Full name of individual providing consent (Patient, patient's guardian/attorney or parent if required)	
Signature	Date

If a parent or guardian has completed this form on behalf of a patient aged 14-17, please confirm the patient is aware of this registration and provided informed consent. ☐ Yes

Consent for MyMedicare registration for patients under 14 years of age must be provided by the patient's parent or legal guardian.

Patients aged 14-17 years must provide their consent to register for MyMedicare.

- A parent or guardian of a patient aged 14-17 years may complete the Registration Form if the 14-17 year old is aware of the registration and has provided their consent for this person to act on their behalf.

For a patient 14 years or older, who lacks capacity to make decisions for themselves, consent for the MyMedicare registration will need to be provided by an individual who is authorised to act on the patient's behalf.

Office use only
Provider Number of preferred GP 0332018F

Please select a box to confirm the patient's eligibility

☐ The patient has had at least 2 face-to-face consultations at the Practice in the previous 24 months

The patient meets the reduced eligibility criteria of at least one face-to-face consultation at the Practice in the previous 24 months and

☐ The Practice is located in MMM6-7

The patient meets one of the exemption criteria:

☐ Children under 18 years whose parent is already registered at this practice
☐ Parents of a child under 18 years who is already registered at this practice
☐ Patient is following a GP they are registered with to this practice
☐ Patient experiencing family and domestic violence
☐ Patient experiencing homelessness

Privacy Statement

The law regulates how Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and the Department of Veterans' Affairs may handle your personal information. Services Australia is collecting your personal information to assess your eligibility for MyMedicare and provide services to you and payments linked to your provider as a result of your MyMedicare registration. Your information will only be shared with relevant government agencies such as the Department of Health and Aged Care, Australian Digital Health Agency and the Department of Veterans' Affairs, where you have agreed, or where the law allows or requires it. The MyMedicare Privacy Notice describes how your information will be managed consistent with our obligations under the *Privacy Act 1988* and the *Australian Privacy Principles*. The notice can be found at MyMedicare – PrivacyNotice

You can also read the:

- Services Australia privacy policy at: www.servicesaustralia.gov.au/privacy
- Department of Health and Aged Care privacy policy at: https://www.health.gov.au/resources/publications/privacy-policy
- Australian Digital Health Agency privacy policy at: https://www.myhealthrecord.gov.au/about/privacy-policy, and
- Department of Veterans' Affairs privacy policy at: https://www.dva.gov.au/privacy-policy.