MAURICE ZEFFERT
Trusted Jewish Aged Care

MAURICE ZEFFERT – DAY THERAPY APPLICATION FORM

119 Cresswell Road, Dianella WA 6059

Phone 9375 4600 Fax 9276 1250 Email mzh@mzh.org.au

CLIENT DETAILS

Name_____DOB_____

Address_____Post Code_____

Phone_____Mobile_____Country of Birth_____

MEDICARE NUMBER_____

MY AGED CARE REFERENCE NUMBER_____

NOK DETAILS……. 1st Contact

Name_____

Mobile_____

Address_____

Relationship to Client_____

Email_____

NOK DETAILS……. 2nd Contact

Name_____

Mobile_____

Address_____

Relationship to Client_____

Email_____

PERSON RESPONSIBLE FOR PAYMENT

Name_____Mobile_____

ADDRESS_____Post Code_____

EMAIL_____

PACKAGE DETAILS

Company_____

Contact Person_____Level_____

Address_____

_____

OFFICE USE ONLY

Confirmation of Level_____Confirmation of Available Funds_____

Client Goals_____

_____

_____ Commencement Date_____

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TRANSPORT REQUIRED? (Cost to be advised) { } YES { } NO

Pick up Address_____

I'M INTERESTED IN?

{ } Wellness and Exercise { } Socialisation

{ } Information and Guest Speakers { } Outings & Lunches

{ } Mental Stimulation { } Other_____

CLIENTS LIFE STORY IN SHORT

Education_____

_____

Work History_____

_____

Social History_____

_____

Hobbies & Interests_____

_____

ENDURING AUTHORITY TO PUBLISH

I_____give my permission for photos of_____attending activities at the Day Lounge at Maurice Zeffert Home (Inc) to be used in the MZH Newsletter, the Maccabean, other Jewish publications and on the Home's website.

If there are any changes to be made to this enduring authority, I will notify the Day Therapy Coordinator in writing.

Signed_____Date_____

IS THERE ANYTHING ELSE WE SHOULD KNOW?

_____

_____

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