Individual RACH Resident After-hours Action Plan Form

phn NORTHERN QUEENSLAND
An Australian Government Initiative

Organisation name:

Completed by: (Your name)

Date completed:

**This document should be regularly reviewed in accordance with local policy.*

Resident details

Full name:

Date of birth:

Preferred first name:

Gender:

☐ Male ☐ Female ☐ Other: *(specify)*

Does this resident identify as Aboriginal, Torres Strait Islander, and/or South Sea Islander?

☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander ☐ None of the above

Does this resident require an interpreter? If yes, please advise which language.

☐ No ☐ Yes **Language:**

Other resident information and notes *(E.g. cultural or religious details about the resident.)*

Emergency information

Emergency contact: *(Name)*

Relationship to resident:

(Mobile) *(Phone)* *(Email)*

Next of kin

Name:

Relationship to resident:

(Mobile) *(Phone)* *(Email)*

Medical information

Does this resident have the cognitive capacity to make their own health care decisions? ☐ No (complete below) ☐ Yes

Medical treatment decision maker: *(Name)* *(Phone)* *(Email)*

General practitioner and practice: *(GP name)* *(Practice name)*

(Mobile) *(Phone)* *(Email)*

Supply pharmacy: *(Name)* *(Phone)* *(Email)*

Is this patient linked with Specialist Palliative Care in Aged Care (SPACE)? ☐ No ☐ Yes

Does this resident have an Advance Care Plan in place? ☐ No ☐ Yes

Does this resident have a Do Not Resuscitate (DNR) order in place? ☐ No ☐ Yes