Individual RACH Resident After-hours Action Plan Form



Organisation name:		Completed by: (Your name)		Date completed:
Resident details		*This document should be i	egularly reviewed in accorda	nce with local policy.
Full name:			Date of birth:	
i un name.			Date of birtin.	
Preferred first name:	ler:			
		Male Female	Other: (specify)	
Does this resident identify as Aborigina	I, Torres Strait Islar	nder, and/or South Sea Isl	ander?	
	s Strait Islander	South Sea		None of the above
Does this resident require an interprete	r? If yes, please adv	vise 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 residen	t:
(Mobile)		(Phone)		(Email)
(Plobile)		(FHORE)		(LITIGII)
Next of kin				
Name:			Relationship to residen	t:
(Mobile)		(Phone)		(Email)
Medical information				
Does this resident have the cognitive ca	apacity to make the	eir own health care decisi	ons? No (complete	below) Yes
Medical treatment decision maker:	(Name)	(Phone)		(Email)
General practitioner and practice:		GP name)		(Dractice name)
General practitioner and practice.	(0	3P Hame)		(Practice name)
(Mobile)		(Phone)		(Email)
Supply pharmacy:	(Name)	(Phone)		(Email)
Is this patient linked with Specialist Palliative Care in Aged		d Care (SPACE)?	No	Yes
Does this resident have an Advance Car		No	Yes	
Does this resident have a Do Not Resuscitate (DNR) order in place?			No	Yes