ROSEWOOD

welcome home

NEW RESIDENT

Admission Application

Applicants Name:	Surname:	First Name:

Next of Kin:	Name:	
	Email:	
	Phone:	Mobile:

Room No:	Facility:	Admission Date:
	Daily Fee on Admission	$
	Means Tested Care Fee	$
	Will NOT be providing Income & addet information to Centerlink: ☐	

(The maximum Means Tested Care Fee will be charged daily until the annual and/ or lifetime cap is reached)

Agreed Accommodation Payment Amount: $ _____ or Fully Supported ☐

(Agreed amount will not cause financial hardship to the resident)

Rosewood Edge: Silver Edge $20 per day ☐ Gold Edge $30 per day ☐

Accom. Payment Type (✓):

I. Refundable Accommodation Deposit (RAD)	☐
2. Daily Accommodation Payment (DAP)	☐
3. Combination of RAD (I) and DAP (2)	☐
4. Combination RAD and DAP - drawdown from RAD	☐
Deposit amount:	

FEES TO BE DEDUCTED FROM RAD (✓)
Daily Fee ☐ DAP ☐ Means Tested Care Fee ☐ Rosewood Edge Fee ☐

Rosewood strongly encourages that you seek Financial Advice and arrange Enduring Power of Attorney/Guardianship representation for the resident prior to admission.

Signature:	Date:
(Applicant or EPA)	
Print Name:	

Approved by (Name):	
Rosewood Care Group Inc:	
Signature:	Date:

Date of Admission:	
Resident Details:	First Name:
	Surname:
	Date of Birth:

Account Responsibility:	First Name:	
	Surname:	
	Address:	
	Email:	
	Statement: ☐ Email ☐ Post	
	Mobile:	Home Phone:
	Relationship:	

SIGNED BY RESIDENT (IF CAPABLE):	
Signature:	Date:
Print Name:	
Witnessed By (Signature):	
Witness's Name:	
SIGNED BY CONSUMER REPRESENTATIVE: ATTORNEY / LEGAL REPRESENTATIVE / NOK / EPA	
Signature:	Date:
Print Name:	
Print Address:	
Witnessed By (Signature):	
Witness's Name:	

Terms & Conditions

1. By signing this form at the space above, the Resident and/or the Authorised Person enter into a legally binding contract with Rosewood Care Group Inc.
2. Under the terms of this legally binding contract, the Resident and/or Authorised Person acknowledge that they are liable for all fees, costs, charges and expenses properly incurred by or on behalf of the Resident in connection with the Resident's occupation of Rosewood Care Group Inc.
3. These fees include, but are not limited to : Daily Care Fees, Income Tested Fees, Wound Care, Continence Aids, Tagging and all amounts owing in respect of an Accommodation Bond or Accommodation Charge (if applicable) levied by Rosewood Care Group Inc, amounts owing under the Extra Services Agreement or Resident's Agreement, and any interest charged by Rosewood Care Group Inc. to the extent that Rosewood Care Group Inc. is permitted to charge interest.
4. In the event of a failure to pay any part of the Fees, the Resident and the Authorise Person will be liable to Rosewood Care Group Inc. for any legal and other costs incurred in recovering the debt.
5. The Resident and the Authorised Person (as applicable) acknowledge that -
   i. Daily Care Fees, Income Tested Fees and Accommodation Charges are billed fortnightly in advance and must be paid in accordance with the Resident's Agreement.
   ii. Interest and Retention charged for Accommodation Bonds is charged monthly retrospective and must be paid in accordance with the Residency Agreement.
6. This form must be signed and returned to Rosewood Care Group Inc. by no later than when the Resident is admitted.
7. Account enquiries should be directed to, in the first instance, the Accounts Receivable Officer.

DIRECT DEBIT FACILITY FOR DAILY CARE FEES & OTHER PAYMENTS

ESTABLISHING DEBIT AUTHORITY IN THE DIRECT DEBIT SYSTEM

In an effort to reduce your bank fee costs, to simplify the payment of your Daily Care Fees and other payments and to prevent any overdue expenses, Rosewood Care Group (Inc) would like to arrange a direct debit facility for you.

This will be done fortnightly in line with Aged Pension payment days via direct debit from your bank account.

Please find enclosed the Direct Debit Request and the Customer Service Agreement.
Kindly fill in the details and return to our office, either in person or by mail.

If you have any queries please do not hesitate to contact the Accounts office on 1300 971 771.

DIRECT DEBIT REQUEST
CUSTOMER SERVICE AGREEMENT

Rosewood Care Group Inc commitment to you is as follows:

- We will advise you by monthly statement or invoice of the drawings.
- Where the due date falls on a non-business day, we will draw the amount on the next business day.
- We reserve the right to cancel the drawing arrangement if drawings are continually returned unpaid by your nominated Financial Institution. Where drawings are returned unpaid we will arrange with you an alternate payment method. A fee may apply for drawings that are returned unpaid.
- We will investigate and deal promptly with any queries, claims or complaints regarding debits, providing a response within 20 business days.

Your commitment to us is as follows:

- It is your responsibility to check with your Financial Institution prior to completing the Direct Debit Request, that direct debiting is available on that account.
- It is your responsibility to ensure that the authorisation on the Direct Debit Request is identical to the account signing instruction held by the Financial Institution of the nominated account.
- It is your responsibility to ensure at all times, that sufficient funds are available in the nominated account to meet a drawing on the due date for payment.
- It is your responsibility to advise us if the account nominated by you, to receive the drawings is altered, transferred or closed.
- It is your responsibility to meet any charges resulting from the use of the Direct Debit System. This may include fees charged to us as a result of returned drawings.
- It is your responsibility to cancel any existing periodical payments.

You may request to defer or alter the agreed drawing schedule, by giving written notice to us. Such notice should be received by us at least 14 business days prior to the due date.

You may stop your individual debit by giving written notice to us. Such notice should be received by us at least 14 business days prior to the due date.

You may cancel the Direct Debit arrangement at any time by giving written notice to us. Such notice should be received by us at least 14 business days prior to the due date. Your nominated Financial Institution is unable to cancel your Direct Debit Arrangement.

All transaction disputes, queries, and claims should be raised directly with us. We will provide a verbal or written response within 20 business days from the date of the notice. If the claim, dispute is successful, we will reimburse you by way of cheque or electronic credit to your nominated account.

Request to establish Debit Authority in the Direct Debit System

☐ 5 Britannia Road, Leederville WA 6007	☐ 67 Cleaver Street, West Perth WA 6005	
I/We Surname:	Given Name:	
Address:		Postcode:
Authorise Rosewood Care Group (Inc.), until further notice in writing, to arrange for funds to be debited from my/our account, at the Financial Institution identified and as described in the Schedule below, any amounts which Rosewood Care Group (Inc.) may debit or charge me/us through the Direct Debit System.		
Identified by Reference Information: **Rosewood Care Group Inc**	Resident's Name:	

The Schedule - Details of Account to be Debited

Account held in the name of:	
Financial Institution BSB:	Account Number:
Financial Institution Name/Address:	
(Insert the name and address of the Financial Institution at which your account is held.) (Please note direct debiting is not available on the full range of accounts. If in doubt, please refer to your Financial Institution.)	

Direct Debit Request Authorisation

I/We have read the Customer Service Agreement that is attached and acknowledge and agree with its terms and conditions. I/We request this arrangement to remain in force in accordance with details set out in the Schedule described above and in compliance with the Customer Service Agreement.	
Account Holder Name/s:	
Account Holder Signature/s:	
Date:	

OPTIMAL
MEDICATION SOLUTIONS

Dear Resident,

What are the benefits of nominating Optimal Medication Solutions (OMS) as your preferred pharmacy?

Optimal Medication Solutions is a unique specialised pharmacy focused solely on resident medication solutions without the distraction of normal retail pharmacy activities. As a family owned business we understand individuality and are dedicated to providing the best service possible to every resident.

Your care team are very familiar with our systems and better placed dealing with the one pharmacy rather than trying to cope with multiple pharmacies. We have created an integrated and secure electronic communication with your home enabling the seamless sharing of medication charts to improve safety, efficient dispensing and the quality of the medication administration process. Furthermore, we provide your home with all the necessary reports for their medication compliance reporting which assists with improving medication management.

At Optimal Medication Solutions, we use Good Manufacturing Practice standards to ensure we systematically provide the best in class medication packing solutions. We have state of the art packing facilities. Our machines and checking systems are new to Australia and best in class. This ensures maximum safety compliance and an extra level of safety for you.

We have our own in-house delivery vehicles, with drivers who are trained, police cleared and vaccinated to deliver your medications with the care and respect they deserve. We have extensive pandemic planning in place, in accordance with the latest COVID-19 updates from the Department of Health. We follow the same approach to emergency management, within an ongoing cycle of activities in the four areas of prevention, preparedness, response and recovery.

Our dedicated Pharmacists are committed to providing 24 hour support for 365 days of the year to ensure your peace of mind. This includes Public Holidays when we have a Pharmacist on call to handle emergencies. We utilise the National Residential Medication Charts (NRMC) designed by the Australian Commission on Safety and Quality in Health Care, to improve medication quality. Our Accredited Clinical Pharmacists provide clinical services including Quality Use of Medicines (QUM) advice, ongoing staff training regards to medicines and their best use and the Residential Medication Management Review (RMMR) referred by your doctor. We help your facility with regular audits of medication storage and charts utilising our own in-house developed audit tool, developed using Best Practice Model guidelines. Our team at OMS is committed to Continuous Quality Improvement and we engage in ongoing learning and training modules to improve safety and service delivery.

Thank you for choosing Optimal Medication Solutions as your partner of health and we look forward to being of service to you.

Yours sincerely,

Gary Gascoigne

Gary Gascoigne, Director

IMPORTANT INFORMATION
For Residents and Families

OPTIMAL MEDICATION SOLUTIONS

ADMISSIONS

Upon admission to help a smooth transition **Optimal Medication Solutions** requires the following documents as Medication cannot be supplied until these are received.

- ☐ Admission Notification Form
- ☐ A complete list of medications signed by the doctor.
- ☐ All current prescriptions (especially Authority Prescriptions)
- ☐ Medicare plus Concession, DVA or Safety Net Details.
- ☐ Prescription Record Form (PRF) from any previous Pharmacy for the current year.

Please be advised forwarded or handed in medications from another pharmacy such as multi-dose packs (blisters/webster) cannot be used by **Optimal Medication Solutions** as the safety and integrity of the medication once dispensed cannot be assured, as per the guidelines issued by the Pharmacy Board of Australia.

DISCHARGES AND HOSPITAL

Your facility will need to advise **Optimal Medication Solutions** if there are any changes in status of residents to avoid unnecessary charges including if you have been admitted to hospital during your stay at the facility.

If residents are discharged from a facility, **Optimal Medication Solutions** can organise for medications and prescriptions to be delivered to the facility prior to discharge or they are welcome to be collected from **Optimal Medication Solutions** or one of our banner locations **Optimal Pharmacy+** stores. Please note **Optimal Medication Solutions** does require the account to be paid in full prior to returning the medication balance.

DISPENSING

As a customer of **Optimal Medication Solutions**, you will have a pill balance for each of the medications that are packed into sachets/ Blisters for you. Every time we dispense a prescription, we add the amount to your pill balance. Every time we pack medications, we reduce the balance.

- **Optimal Medication Solutions** is authorised to dispense government subsidised medication according to the Pharmaceutical Benefits Scheme (PBS). More information on the PBS can be found at *www.pbs.gov.au/pbs/home*
- Doctors are required to supply **Optimal Medication Solutions** with prescriptions in a timely manner. In the rare cases this does not happen it may be necessary to reprice those items as **private** items due to the fact that the PBS denies subsidy. The repricing of the item does not alter the legal requirements of the Doctor to provide the prescription.
- **Optimal Medication Solutions** will advise the facility before any supply is interrupted due to prescriptions not being supplied by the resident's doctor.
- If a resident is going on social leave or holidays, we can provide medications in advance. The facility is responsible for ordering the medications and must give adequate time to arrange this supply.

MEDICATION CHANGES

Doctors often are required to make medication changes to optimise treatment and the urgency is indicated on the request order – "Urgent next dose" – "Within 24 hours" or "With next weekly pack".

Ideally changes should be made for "With next weekly pack" in order to reduce the amount of medication wastage and impact on the account charges, as medications packed in sachets/ blisters cannot be reused as per the Pharmacy Board of Australia guidelines. If sachets/ blisters need replacing, then medications must be re-dispensed. Medications that have not all been used but have been ceased by the doctor cannot be returned for credit.

IMPORTANT INFORMATION
For Residents and Families

OPTIMAL MEDICATION SOLUTIONS

OWING PRESCRIPTIONS

To ensure prompt medication supply, **Optimal Medication Solutions** often dispenses medication on a faxed medication profile or photo order through our online portal.

An "Owing Prescription" is the name given to an item that **Optimal Medication Solutions** dispenses in good faith awaiting a prescription from the resident's Doctor.

- This prescription is a legal requirement. If a Doctor does not supply a prescription with the exact date when the medication was supplied as "owing", the pharmacy must cancel the originally dispensed item and re-dispense the item. This will then appear on the account as the date it was dispensed and not the date it was supplied, there will also be a visible (-) negative and positive showing this workaround. This may then seem like multiple dispensing of the same item in one month's account. However, as above the medication would have already been previously supplied and only been charged to the account on the date of dispensing.
- Owing prescriptions that are still outstanding after a resident is deceased must be re-charged at the non-PBS price even if a prescription is sourced. This is only due to the fact that a person's Centrelink and Medicare concessions (where appropriate) are cancelled and subsidies are no longer available.

ACCOUNTS

Optimal Medication Solutions provides an account to all residents and the credit policy is strictly a 25 day account with payment in full each month to ensure continuous supply. Accounts are not covered by the facility and are the responsibility of the resident/ person(s) responsible for the resident's finances.

- Account invoice/ statements are automatically generated on the first day of the month for the previous month's charges. If a payment was processed on the last business day of the previous month, then the amount paid will not reflect on your new tax invoice/ statement. Direct Debit payment of your account will avoid this issue.
- Accounts that become 60 days or more overdue will incur a $5.00 overdue fee applied each month until the account is paid full. We do offer payment plans on a case by case basis for customers in need.
- Accounts can be paid via Credit Card over the phone, Auto Credit card, Direct Debit, Electronic Funds Transfer, Bank Deposit or pay by Cash at **Optimal Medications Solution**.
- When paying via electronic funds transfer or bank deposit please be reminded to use the customer number and surname that is detailed on you tax invoice/ statement, this is important to the allocation of your payment to the customer account.

Account questions can be emailed to *accounts@optimalms.net.au* or alternatively, in writing to:

Accounts Department
Optimal Medication Solutions
101 Norma Road
MYAREE WA 6154

Otherwise please direct queries by phone to the Accounts Department between 9am and 4pm Monday to Friday on ***(08) 9333 0111***.

All account queries will be looked into and addressed appropriately. Please be aware that the phone sometimes may be busy, due to the detailed nature of account enquiries and because of the need to research detailed queries there may be a delay in response, messages left for the Accounts Manger will be returned as soon as possible.

On Behalf of Optimal Medication Solutions Team,
Thank You.

PHARMACY ADMISSION NOTIFICATION (1 of 5)

OPTIMAL MEDICATION SOLUTIONS

RESIDENT INFORMATION

DATE / /

First Name: | Last Name:

Respite? ☐ YES ☐ NO | Gender: ☐ Male ☐ Female | Date of Birth:

Facility: | **Ward Area:** | **Room / Bed No:**

Allergies:

Facility Doctor: | Doctor's Number:

Brand Specific Medication:

Medication Supply Start Date from:

Does this resident have a living spouse residing at this facility? ☐ YES ☐ NO

If YES, please provide their Full Name:

PHARMACEUTICAL BENEFITS DETAILS

Please tick appropriate box after sighting entitlement card.
This must be complete for the correct entitlement and charging of resident medications.

Previous Pharmacy Name:

Medicare No: | Expiry:

Note: the final digit refers to the Resident Ref. No. on Card

☐ Pension/ Concession | Card Number: | Expiry:

☐ Repat (Gold) ☐ Repat (White) ☐ Repat (Orange) | Repat Number:

☐ Safety Net Entitlement | Card Number:

Please be advised, this Entitlement Card expires on the 31st December every year.

☐ None
This resident does not hold any Pension/Concession/Repat/Entitlement

Is the resident registered for Closing The Gap (CTG)? ☐ YES ☐ NO

Does the resident identify as Aboriginal or Torres Strait Islander? ☐ YES ☐ NO

NATIONAL DIABETES SERVICE SCHEME (NDSS)

Is the resident diabetic? ☐ YES ☐ NO | If Yes, is he/she registered with NDSS? ☐ YES ☐ NO

NDSS Registration Number:

PLEASE TURN OVER →

PHARMACY ADMISSION NOTIFICATION (2 of 5)

OPTIMAL MEDICATION SOLUTIONS

NEXT OF KIN DETAILS

First Name: | Last Name:

Address:

Suburb: | State: | Postcode:

Email: | Phone:

PERSON RESPONSIBLE FOR ACCOUNT PAYMENT

First Name: | Last Name:

Address:

Suburb: | State: | Postcode:

Email: | Phone:

Prefered method for receival of tax invoice ☐ Email ☐ Post

Is this person under the public trustee? ☐ YES ☐ NO TM Number:

Does this resident fall under the facility Trust programme? ☐ YES ☐ NO
Please discuss this with your facility, this does not apply to all residents or facilities

Prefered method of payment
☐ Direct Debit
If Direct Debit payment method is preferred, complete the Direct Debit Request form provided.
☐ Tax Invoice ☐ Alternative Payment Options (Card, Cheque or Bank Transfer)

I/ We agree to pay all pharmacy costs whilst I or my relative is a resident in this facility. Accounts are issued to the nominated person as advised by the facility.

I, (Resident / Relative) declare that all information provided within this document to be true to the best of my knowledge. Should the provided information be incomplete or insufficient, I authorise **Optimal Medication Solutions** to contact Medicare or relevant authorities to obtain the required information.

Resident / Relative Sign Here

Signature:

Name:

Date:

RN / Staff Sign Here *If required to sign on behalf of Resident/Relative*

Signature:

Name:

Date:

FACILITY RN / STAFF CHECKLIST

☐ Medication Profile or Medication Documentation provided and supplied to pharmacy?
☐ Current presciptions provided? (if available)
☐ Copies of Medicare and/or pharmaceutical benefit card? (if available)
☐ Resident photo has been taken and supplied?

PLEASE TURN OVER →

DIRECT DEBIT REQUEST (3 of 5)

CUSTOMER ACCOUNT NUMBER:
(OFFICE USE ONLY)

OPTIMAL MEDICATION SOLUTIONS

Request and Authority to debit the account named below to pay Goldpack Pty Ltd t/as Optimal Medication Solutions
ABN: 95088052484

DIRECT DEBIT REQUEST AND AUTHORISATION

Name of Resident

First Name: Last Name:

Request and authorise Optimal Medication Solutions User ID 303956 to arrange, through its own financial institution, a debit from your nominated account any amount Optimal Medication Solutions has deemed payable by you.

This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from your account held at the financial institution you have nominated below and will be subject to the terms and conditions of the Direct Debit Request Service Agreement. Optimal Medication Solutions processes all direct debit request on the 21st of every month for the previous months charges. If the 21st falls on a Saturday, Sunday or Public holiday it will be debited on the next following business day.

NOMINATED ACCOUNT DETAILS

Name of Financial Institution:

Address of Financial Institution:

Name of Bank Account to be Debited:

BSB: Account Number: ☐ Direct Debit monthly account

Payment Details: *for fixed amount per month* $

The first debit may be made on: / /
and at the following intervals after that monthly

NEXT OF KIN / CONTACT FOR ACCOUNT DETAILS

First Name: Last Name:

Address:

Email: Phone:

ACKNOWLEDGEMENT

By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between you and Optimal Medication Solutions trading under Goldpack Pyt Ltd as set out in this Request and in your Direct Debit Request Service Agreement.

ACCOUNT SIGNATURES

Signature: Signature:

Name: Date: Name: Date:

Please email this signed copy to the accounts department on **accounts@optimalms.net.au**

PLEASE TURN OVER →

DIRECT DEBIT SERVICE AGREEMENT (4 of 5)

OPTIMAL MEDICATION SOLUTIONS

The following is your Direct Debit Service Agreement with Goldpack Pty Ltd t/as Optimal Medication Solutions, ABN 95088052484. The agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit Provider.

We recommend you keep this agreement in a safe place for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR form.

Definitions

- account means the account held at your financial institution from which we are authorised to arrange for funds to be debited.
- agreement means this Direct Debit Request Service Agreement between you and us.
- banking day means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.
- debit day means the day that payment by you to us is due.
- debit payment means a particular transaction where a debit is made.
- direct debit request means the Direct Debit Request between us and you.
- us or we means Optimal Medication Solutions (the Debit User) you have authorised by signing a direct debit request.
- you means the customer who signed the Direct Debit Request.
- your financial institution means the financial institution nominated by you on the DDR at which the account is maintained.

1. **Debiting your account**
By signing a Direct Debit Request, you have authorised us to arrange for funds to be debited from your account. You should refer to the Direct Debit Request and this agreement for the terms of the arrangement between us and you.

   We will only arrange for funds to be debited from your account as authorised in the Direct Debit Request If the debit day falls on a day that is not a banking day, we may direct your financial institution to debit your account on the following banking day. If you are unsure about which day your account has or will be debited you should ask your financial institution.

2. **Amendments by us**
We may vary any details of this agreement or a Direct Debit Request at any time by giving you at least fourteen (14) days' written notice.

3. **Amendments by you**
You may change, stop or defer a debit payment, or terminate this agreement by providing us with at least fourteen (14) days' notification by writing to: 101 Norma Road Myaree 6154 WA, email on accounts@optimalms.net.au, telephoning us on 08 9333 0111 during business hours or arranging it through your own financial institution.

4. **Your obligations**
Is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the Direct Debit Request.

   If there are insufficient clear funds in your account to meet a debit payment:
   (a) you may be charged a fee and/or interest by your financial institution;
   (b) you may also incur fees or charges imposed or incurred by us; and
   (c) you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be in your account by an agreed time so that we can process the debit payment.

   You should check your account statement to verify that the amounts debited from your account are correct.

   If the resident customer is discharged or passes away, the final account balance will be direct debited and the account will be closed with a final statement being sent out.

5. **Dispute**
If you believe that there has been an error in debiting your account, you should notify us directly on 08 9333 0111 or accounts@optimalms.net.au and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up with your financial institution direct.

   If we conclude as a result of our investigations that your account has been incorrectly debited we will respond to your query by arranging for your financial institution to adjust your account (including interest and charges) accordingly. We will also notify you in writing or by email of the amount by which your account has been adjusted. If we conclude as a result of our investigations that your account has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding in writing.

6. **Accounts**
You should check:
   (a) with your financial institution whether direct debiting is available from your account as direct debiting is not available on all accounts offered by financial institutions.
   (b) your account details which you have provided to us are correct by checking them against a recent account statement; and
   (c) with your financial institution before completing the Direct Debit Request if you have any queries about how to complete the Direct Debit Request.

7. **Confidentiality**
We will keep any information (including your account details) in your Direct Debit Request confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

   We will only disclose information that we have about you:
   (a) to the extent specifically required by law; or
   (b) for the purposes of this agreement (including disclosing information in connection with any query or claim).

8. **Notice**
If you wish to notify us in writing about anything relating to this agreement, you should write to 101 Norma Road Myaree 6154 WA or accounts@optimalms.net.au. We will notify you by sending a notice in the ordinary post to the address you have given us in the Direct Debit Request.

   Any notice will be deemed to have been received on the third banking day after posting.

PLEASE TURN OVER →

CREDIT CARD ONLY (5 of 5)
DIRECT DEBIT REQUEST (DDR)

OPTIMAL MEDICATION SOLUTIONS

CUSTOMER'S AUTHORITY

Name of Customer giving Authority for the DDR:

Authorise and request you, Gold Pack Pty Ltd trading as Optimal Medication Solutions APCA user ID Number: 303956

To arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System or to debit my/our Account by any other means.

Optimal Medication Solutions processes the DDR request transaction on the 2nd to 3rd business day of the month for the previous months charges.

Customer Number:

First Name: Last Name:

House / Facility Name:

Address:

Suburb: State: Postcode:

Email: Phone:

Name on Card:

Type of Card: ☐ Mastercard ☐ VISA

Card Number:

Expiry: / CVV Code:

DECLARATION

I / We (if in joint names) also authorise the Following:

1) The Debit user to verify the details of the above mentioned account with my/our both signature's – financial institution.
2) The financial institution to release information allowing the Debit user to verify the above mentioned details.

Signature: Signature:

Name: Name:

Date: Date:

UNDERSTANDING YOUR PHARMACY ACCOUNT

Charges and Payment Information

OPTIMAL MEDICATION SOLUTIONS

As a customer of **Optimal Medication Solutions**, you will have a pill balance for each of the medications that are packed into sachets for you. Every time we dispense a prescription, we add the amount to your balance. Every time we pack medications, we reduce the balance. When dispensing medications, there may be a delay in allocation to the account due to operating hours. Upon request, we can provide a dated dispensing record for your account.

When your packed medications are changed by doctors, we are required to repack a new roll based on your facility's requirements with the new medications in them, this can sometimes lead to a higher usage of pills. Unfortunately, we are unable to reuse previously supplied medications as per the guidelines of T**he Pharmacy Board of Australia**. If needed, we are happy to provide a reconciliation upon request.

We endeavour to provide the very best value for all our customers. Here is an example of the additional value we do not charge our customers for:

- 24/7 on call service (priceless)
- Packaging of the medications (value of $5 per week)
- Delivery to the Facility (value of $10 per week)
- Medication Charting (value of $5 per month)

We are very competitive with our pricing and have a dedicated team to ensuring that prices are reviewed on a regular basis, but please don't hesitate to contact us at accounts@optimalms.net.au and we can investigate potential cost savings on your medications. When these factors are considered, we are confident that we do provide excellent service and value to our customers.

Optimal Medication Solutions provides an account to all residents and the account credit policy is strictly a 25 day account with payment in full each month to ensure continuous supply.

Pharmacy Accounts are NOT covered by the facility and is the responsibility of the resident and or person/s responsible for the resident's finances.

Pharmacy Account invoices/ statements are automatically generated on the first day of the month for the previous month's charges. If a payment was processed on the last business day of the previous month, then the amount paid will not reflect on your new tax invoice/ statement. Direct Debit payment of your account will avoid this issue.

Accounts that become 60 days+ overdue will incur a $5.00 overdue fee applied each month until the account is paid in full. We do offer payment plans on a case by case basis for customers in need.

When making an account payment, please follow one of the below ways to pay:

- You can call our accounts team on (08) 9333 011 to make a debit/ credit card payment over the phone or be added to our auto credit card processing list.
- Fill in a direct debit request form. This is processed on the 21st of every month
- Electronic funds transfer or bank deposit:

  Name: Optimal Medication Solutions
  BSB: 086-082 **Account Number:** 362819590
  Reference: *Customer number on your tax invoice/statement.*

If you have a query in regards to your account including the pricing of any items, please do not hesitate to contact us at *accounts@optimalms.net.au* and we will explain or review any charges and of course on the rare occasion there may be an error we will immediately resolve the problem.

Date: _____

Dear Dr. _____

_____ has been admitted as a permanent resident at Rosewood Care Group.

Doctor's Name _____

Practice Name _____

Practice Address _____

Leederville Fax - 08 6323 3393

West Perth Fax - 08 6210 1302

We require the following documents:

- Full medical summary
- Vaccination records
- Specialist letters
- All other relevant documentation

If these could be faxed to Leederville: 08 6323 3393 and West Perth: 08 6210 1302 as soon as possible it would be much appreciated.

Kind Regards,

Rosewood Care Group

PERMISSION TO RELEASE MEDICAL RECORDS

Name of Resident or Guardian:	
Signed:	Date:

Resident Name:	
☐ Advanced Health Directive is in place	
☐ EPG ☐ EPA ☐ Representative	
Name:	Relationship:
Signature:	Date:

Clinician involved in discussion:	
Signature:	Date

FOR CPR	A ☐	**FOR TREATMENT OF ALL REVERSIBLE ILLNESSES** • (There can be clinical implications involved with CPR, please speak to a clinician for more information). NOTE: Rosewood staff will not attempt CPR • For transfer to hospital/Emergency department/ICU if treatment can not be provided in the facility
NOT FOR CPR	B ☐	**FOR TREATMENT OF ALL REVERSIBLE ILLNESSES WITH LIMITATIONS** • CPR is not attempted • For transfer to hospital/Emergency department/ICU if treatment can not be provided in the facility
	C ☐	**FOR TREATMENT OF ALL REVERSIBLE ILLNESSES WITHIN THE LIMITS OF THE FACILITY** • CPR is not attempted • For non-invasive treatment at Rosewood • Not for admission into hospital
	D ☐	**TREATMENT AIMS TO MAINTAIN COMFORT** • CPR is not attempted • Comfort based measures only

Commonly known as 'the flu', influenza is a highly contagious disease that can be serious, debilitating and affect the whole body. The flu is caused by a particular group of RNA viruses (Orthomyxoviridae) and is spread by infected people coughing or sneezing as well as from surfaces contaminated by respiratory secretions. It's easy to catch and spread and hard to avoid.

Annual influenza vaccination is the most important measure to prevent influenza and its complications and is recommended for all people aged 6 months and over. Seasonal influenza activity is expected to continue in 2023 following a resurgence of influenza in 2022.

Influenza vaccines can be co-administered (given on the same day) as any COVID-19 vaccine. Vaccination is particularly important for people in aged care facilities as they are at high risk of complications from influenza.

If a person had a 2022 influenza vaccine in late 2022 or early 2023, they are still recommended to receive a 2023 formulation of influenza vaccine.

I, _____ consent to influenza vaccination on myself/ _____

(insert name if consenting on resident's behalf) & indicate if:

☐ Enduring Power of Guardian OR
☐ Next of kin

REGISTERED AGE GROUP	VACCINE							
	Vaxigrip Tetra 0.5ml (Sanofi)	**Fluarix Tetra** 0.5ml (GSK)	**Afluria Quad** 0.5ml (Seqirus)	**FluQuadri** 0.5ml (Sanofi)	**Influvac Tetra** 0.5ml (Viatris)	**Flucelvax Quad** 0.5ml (Seqirus)	**Fluad Quad** 0.5ml (Seqirus)	**Fluzone High-dose Quad** 0.7ml (Sanofi)
6 - 24 months (<2 years)	✓	✓	x	✓	✓	x	x	x
> 2 to <5 years	✓	✓	x	✓	✓	✓	x	x
>5years to <60 years	✓*	✓*	✓*	✓	✓	✓	x	x
>60 to <65years	✓*	✓*	✓*	✓	✓	✓	x	✓
>65years	✓	✓	✓	✓	✓	✓	✓	✓

I understand the possible risks of the vaccination (injection site pain, tiredness, muscle aches, low grade fever and, very rarely, anaphylaxis), AND:

- ☐ I have never experienced an allergic reaction to a flu vaccination
- ☐ I am not allergic to latex, eggs or feathers
- ☐ I am not allergic to neomycin, polmyx or gentamicin (types of antibiotic)
- ☐ I am not pregnant (flu vaccination is still recommended during pregnancy but it is best if it is given by your doctor)

Signature:	Date:
Signature of person administering vaccine:	Date
Batch number:	

Place sticker or write batch number

Pharmacy Programs Administrator

RESIDENTIAL MEDICATION MANAGEMENT REVIEW PATIENT CONSENT

COLLECTION AND USE OF YOUR PERSONAL INFORMATION

The Service Provider is collecting and using this personal information about you in order to determine your eligibility, and if eligible, provide you a service under the Seventh Community Pharmacy Agreement. The Service Provider may also collect your personal information from your Community Pharmacy.

The Service Provider can be contacted using the details below:

Service Provider Name	Optimal Medication Solutions		
Telephone Number			
Date of Service		**Time of Service**	

The Service Provider will disclose your personal information such as your Medicare Number, name, date of birth, details about your eligibility for the service and other health information to the Pharmacy Programs Administrator and the Australian Government in order to claim a payment for the delivery of the service to you. The Service Provider may also disclose your personal information to your Community Pharmacy, other members of your healthcare team and another Service Provider as a requirement of conducting the service.

The Pharmacy Programs Administrator has a privacy policy that you can read at www.ppaonline.com.au. You can also obtain a copy of the privacy policy by contacting the Pharmacy Programs Administrator using the contact details on the website above. The privacy policy contains information about:

- How you may access the personal information that the Service Provider, the Pharmacy Programs Administrator or the Australian Government holds about you and how you can seek to correct it
- How you may complain about a breach of the Australian Privacy Principles.

The Australian Government is unlikely to disclose your personal information to overseas recipients.

If you do not wish to provide all of the personal information or consent to the collection and disclosure of the personal information required, the Service Provider will not be able to provide you with a funded service.

WRITTEN PATIENT CONSENT

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).

I consent to the Service Provider (including all accredited and registered pharmacists undertaking the service on behalf of the Service Provider) collecting and disclosing personal information for the purpose indicated above for:

Patient Name			
Signature		**Date**	
Name, relationship and address of Person providing consent on Patient's behalf (if not patient) including details of the basis of their ability to give consent			

DR PRATH BALA BDSC (UWA)
P: 0401314228
E: INFO@AGEDCAREDENTISTRY.COM.AU
F: 63163356
PO BOX 979
INNALOO CITY WA 6918
WWW.AGEDCAREDENTISTRY.COM.AU

Dental Consent Form

I Mr/Mrs/Ms _____

Give my full consent to Aged Care Dentistry to carry out a dental examination and treatment on

Mr/Mrs/Ms _____

DOB _____ Facility _____

As the Enduring Guardian / EPA in charge of health affairs of the above stated person, I authorise Aged Care Dentistry to complete the following dental treatment:

Clean of all teeth: Cost $410.00 – 1 hour appointment with Oral Health Therapist. Visit includes cleaning, fluoride treatment, free examination (without x-rays), travel for staff.

Please note: The free oral screen will indicate any obvious visual areas of potential infection or concern, which may need to be investigate further. The screening is not and does not substitute a comprehensive examination. A comprehensive examination includes x-rays, photographs, written report, and treatment options / quote. This can be organised if desired.
Cleaning: The cleaning will be completed to the best of our ability and is not a substitute for a deep clean of the gums where periodontal (gum) disease is present. If further deeper cleaning is required. This will be mentioned after the basic (above gum) cleaning and additional fees will be quoted. If a patient is uncooperative, the above cleaning fee may still apply.

After completion of treatment, an invoice will be issued and this must be finalised on the day of issue.

Guardian Name: _____

Guardian Phone Number: _____

Guardian Signature: _____

Date: _____

Please return signed consent form to Aged Care Dentistry

Please complete as much of this form as you are able to and as you feel comfortable doing. Don't worry if there are things you don't know - just the things you do know will be a great help.

Place of birth & where childhood was spent:			
Year of emigration & port of arrival (if relevant):			
Language(s) spoken:		Preferred Language:	
Proficiency in spoken English:	☐ Good ☐ Basic ☐ None		
Interpretrer required:	☐ Yes ☐ No		
Last place of residence:		Other places of residences:	
Names & occupations of parents:		Names of brothers & sisters:	
Marital Status:	☐ Single ☐ Widowed ☐ Divorced/Separated ☐ Married/Partnered		
Partner's name:		Vocation of partner:	
Date & place of wedding:			
Names of children:		Names of great-grandchildren:	
Names of grandchildren:		Names of other significant relatives:	
Names of closest friends (past & present):		Names & types of family pets (past & present):	

Religion:		Extemt of involvement:
Desire to continue practicing religion:		
Ethnicity:		
Cultural Customs/Habits/Beliefs/Values/Dress/Food/Special days:		

Education	Schools attended:	
Level of education attained (eg. year 10, diploma, uni):		
Comments on education:		
Employment	First job:	Age at retirement:
Subsequent jobs:		
Work skills:		
Retirement Interests (travel etc):		

Community Activities	Volunteer work:
Social roles/Club membership:	

Activities	Please tick the activities in which you would be interested in participating:	
☐ Music/concerts	☐ Outings	☐ Social events
☐ Craft	☐ Arts & creative activities	☐ Sensory/pampering
☐ Exercises	☐ Outdoors (including gardening)	☐ Manicures
☐ Games	☐ Education/brain exercise	☐ Massage
☐ Home activities (eg. cooking)	☐ Pet therapy	☐ Aromatherapy
☐ Reading/talking books	☐ TV/movies	☐ Relexology
☐ Religious/spiritual	☐ Radio	☐ Other: _____

Personal Preferences	
Favourite foods:	
Favourite alcoholic drink:	Favourite non-alcoholic drink:
Disliked foods/drinks:	
Smoking: ☐ Never ☐ Past ☐ Present	
Favourite musicians/songs:	
Favourite TV shows/movies:	
Favourite radio station:	
Favourite spots/teams:	
Favourite reading material/genres (books/magazines/newspaper/internet):	
Would you like to join our visiting library?	☐ Yes ☐ No
Favourite animals:	
Past hobbies/interests:	
Current hobbies/interests:	
Do you wish to continue voting?	☐ Yes ☐ No
Are there any topics you do not wish to talk about?	
Do you like to be hugged, prefer to shake hands or prefer no physical contact?	

Social Interaction		
☐ Initiates conversation	☐ Initiates activity	☐ Prefers own company
☐ Enjoys others' company	☐ Enjoys group activities	☐ Enjoys one-to-one interaction

Signed:	Date:	Relationship:

Restrictive Practices

From I July 2021, amendments to the Aged Care Act and Quality of Care Principles have been implemented to minimise the use of restrictive practices (restraints), and where a restrictive practiceis used, to ensure that it is used or applied in accordance with legislative obligations. Informed consents must be obtained for each/all restrictive practices.

The locking of doors and gates and the use of keypad-controlled/swipe card-controlled doors is considered Environmental Restraint as it restricts free access to all parts of the facility. It is suitable for people who, because they are living with dementia or similar, are at risk of wandering into harm or at risk of incurring injury.

The above means all residents are potentially subject to this form of "Restraint". To maintain balance between ensuring the safety of all residents and maintaining freedom of movement, approved residents will be given swipe-card access, subject to clinical assessment. Some residents may not be assessed as suitable for use of a swipe card but, may ask staff to open doors for them.

Rosewood will also lock external doors at night for security purposes.

Residents/families are required to give informed consent.

I hereby consent to accommodation for myself/ relative/loved one. I am aware of the following:

- Access to and from that area is by entry of a code into a keypad or swipe card in order to unlock the door;
- If I am unable to remember that code or misplace my swipe card I may need to ask for staff assistance should I wish to exit;
- I understand that some residents who are "at risk" of getting lost if they leave the home unaccompanied may also reside here, and I am aware that I am not to give the key code/swipe card to any other person in the building.

Resident Name:
Room:
Date:
Consent given by (Print Name):
Signature:
Relationship to Resident: (If not signed by the resident please indicate below)
☑ EPA ☑ EPG ☑ Other (eg. Son, Daughter) _____

Mail Redirection	
☑ Resident to receive personal mail	Redirect legal and financial mail to:
☑ Resident to receive legal and financial mail	Address:

Photography Consent		
☑ Publicity / Media Stories:	☑ Internal Newsletters	☑ I do not authorise any photos to be published
☑ Rosewood's Social Media	☑ Internal Resident Photo Montages	

Preferred Funeral Service Provider Name:		
Address:		Phone:
☑ Burial ☑ Cremation	Special Requirements:	

Enrol to vote or update your details

You can complete this form online today at **www.aec.gov.au**

AEC Australian Electoral Commission

You can use this form to:

- **enrol to vote**
- **change your residential or postal address, and/or**
- **change your name**

on the electoral roll for federal, state and local government elections in Western Australia.

Who can enrol and vote?

It is compulsory for all eligible Australian citizens over 18 years to enrol to vote. You are eligible to enrol and vote if you:

- are an Australian citizen, or a British subject who was enrolled on 25 January 1984
- are 18 years or older, and
- have lived at your address for at least one month.

*For Western Australian electors only, you are eligible to enrol and vote if you were a British subject enrolled between 26 October 1983 and 25 January 1984 inclusive.

You can enrol at 16 years for federal purposes but cannot vote until you are 18. For Western Australian electors the minimum age for enrolment is 17.

Within three weeks of receiving your enrolment form the AEC will confirm your enrolment. We may seek further information from you and confirm your enrolment using any of the contact details you provide.

Special enrolment

Special category enrolment forms are available if you:

- are temporarily overseas
- cannot attend a polling place on election day
- believe that having your address shown on a publicly available roll may endanger your safety or that of your family
- have no fixed address
- are in prison
- are physically incapable of signing your name
- are working in Antarctica.

For more information

Australian Electoral Commission
www.aec.gov.au or **13 23 26**

Western Australian Electoral Commission
www.elections.wa.gov.au or **13 63 06**

Returning your form

Post Australian Electoral Commission
Reply paid 9867
PERTH WA 6848
(No stamp is needed if posted in Australia)

Fax 02 6293 7656

Upload Upload your scanned signed form at **www.aec.gov.au/return**

In person To any AEC office

Who has access to your enrolment information?

The Commonwealth of Australia

The Australian Electoral Commission (AEC) is authorised under the *Commonwealth Electoral Act 1918* (CEA) to collect and verify the information you have been asked to complete on this form. The information provided will assist the AEC to maintain electoral rolls.

The AEC may disclose electoral information to persons or organisations in accordance with the CEA. This may include:

- access to the publicly available electoral roll (containing names and addresses) which may be inspected at electoral offices
- state and territory electoral authorities
- Members of Parliament, Senators, registered political parties, and candidates for the House of Representatives
- approved medical research and public health screening programs
- any agencies, persons or organisations prescribed in the Electoral and Referendum Regulation 2016.

For more information on privacy, visit **www.privacy.gov.au**

The State of Western Australia

Similar information to that provided to Commonwealth agencies is provided by the Western Australian Electoral Commission to state agencies for law enforcement and medical research and to local governments for electoral purposes.

Help in other languages

عربي	1300 720 132	Arabic	Język polski	1300 720 143	Polish
中文	1300 720 135	Cantonese	Português	1300 720 145	Portuguese
Hrvatski	1300 720 136	Croatian	Русский язык	1300 720 146	Russian
Ελληνικά	1300 720 137	Greek	Српски	1300 720 147	Serbian
Italiano	1300 720 138	Italian	Español	1300 720 148	Spanish
ខ្មែរ	1300 720 134	Khmer	Türkçe	1300 720 149	Turkish
한국어	1300 720 468	Korean	Tiếng Việt	1300 720 152	Vietnamese
Македонски	1300 720 139	Macedonian	**Other languages**	**1300 720 153**	
中文	1300 720 142	Mandarin			

If you are deaf, or have a hearing or speech impairment

Contact the AEC through the National Relay Service (NRS):

- TTY – 133 677 then ask for 13 23 26
- Speak and Listen – 1300 555 727 then ask for 13 23 26
- Internet relay – connect to the NRS then ask for 13 23 26

WESTERN AUSTRALIAN Electoral Commission

Enrol to vote or update your details

for federal, state and local government elections in Western Australia

You can complete this form online today at **www.aec.gov.au**

I2 Office use only – Date received

Instructions

Notation CATS NIN

1 Your current name

If completing by hand use a ✘ where appropriate. Use black or blue pen and BLOCK LETTERS

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

Given name(s)

If notifying a change of name

Previous family name

Previous given name(s)

2 Date of birth (dd/mm/yyyy)

Gender

Occupation

3 Current residential address

Clearly identify your residential address. A locality name or mail service number is not enough

State Postcode

Current postal address

Leave blank if the same as your residential address

State Postcode

If notifying a change of address

Previous residential address

State Postcode

4 Phone numbers

Mobile

Daytime ( )

Email address

5 Citizenship status

To enrol you must be an Australian citizen, or a British subject who was on the Commonwealth electoral roll on 25 January 1984

For Western Australian electors only, if you were a British subject enrolled between 26 October 1983 and 25 January 1984 inclusive

☐ **Australian citizen by birth** Town of birth State or territory

OR

☐ **I have become an Australian citizen** Citizenship certificate number

Country of birth

Name on citizenship certificate

OR

☐ **British subject who was enrolled on 25 January 1984** Country of birth

Name on 25 January 1984

6 Evidence of your identity

Complete **ONE** option only

☐ **Australian driver's licence** Number State or territory

OR

☐ **Australian passport** Number

OR

☐ **A person who is on the Commonwealth electoral roll will confirm my identity**

Person's name and address (BLOCK LETTERS)

Date of birth (dd/mm/yyyy)

Declaration by person confirming your identity

- *I am on the Commonwealth electoral roll, and*
- *I confirm the identity of the applicant.*

Signature / /

7 Your declaration

- *I am eligible to enrol at my current residential address as listed at Question 3 and claim enrolment for federal, state and local government elections in Western Australia*
- *The information I have given on this form is true and complete, and*
- *I understand that giving false or misleading information is a serious offence.*

Your signature or mark

Please print and sign your form before returning it to an address shown on page 1 / /

NOTE: If the elector makes a mark because they are unable to sign their name, they must have a witness who saw them mark the form, sign below.

/ /

Print Clear

All appliances that are brought into Rosewood are to be tested and tagged prior to use.
The primary reason behind doing testing and tagging is to ensure the safety of the people in the workplace coming into contact with the appliance, while also minimising the risk of an electrical hazard.

Resident Name: _____

Room Number: _____

Leederville

☐ Citrus ☐ Olive Grove ☐ Jacaranda ☐ Magnolia

West Perth

☐ Balmoral ☐ Windsor ☐ Waterford ☐ Kensington

I acknowledge I am the Resident/Next of Kin /Enduring Power of Attorney for

_____ who is a resident in room number _____

I/We have been informed we are required to have all electrical items tagged on admission and annually thereafter.

I/We authorise Rosewood to charge the nominal amount to have this attended to by a licensed electrical tester, and charged to my/our account.

Signed:	Date:
Witnessed:	

Office Use Only	
Actioned by:	Date:

Residents have a choice of either the Silver Edge Package at $20 per day or the Gold Edge Package at $30 per day which is currently subsidised by Rosewood to take into account the potential inability of some residents to utilise all benefits due to a decline in functionality and/or capacity.

	SILVER	GOLD
Daily rate	$20.00	$30.00
Your Entertainment		
Personal television in the bedroom	✓	✓
Standard television subscription	✓	✓
Communal daily newspaper	✓	✓
Special events and live entertainment	✓	✓
Your Dining & Beverages		
Barista style coffee available to all residents and visitors	✓	✓
Access to the private banquet dining room (once a year)		✓
Personal fridge in room	✓	✓
Friday afternoon social hour	✓	✓
Your Access & Connections		
Luxury amenities	✓	✓
Security & 2x security access cards	✓	✓
Access to Wi-Fi	✓	✓
Your Therapeutic Treatments		
Weekly hair salon appointments	✓	✓
One of the following per week:		
Aromatherapy treatments, OR		✓
Massage therapy treatments, OR		✓
Reflexology treatments		✓

Name		
Room Number		
Rosewood Edge Package		
Daily Fee		
Effective Date		
Applicant or EPA		
Signed:	Date:	

Optional Services	Pricing
Hair salon treatment	Request price list
Boardroom hire	$100
Catering for boardroom	Request price list
Family support room	$75
Bus outings	$10
Additional security cards	$22
Individual newspapers	Request price list
Theraputic treaments	Request price list

Please provide copies of the following documents when submitting Admission Package:	
☐	Medicare card
☐	Covid vaccine certificate
☐	Flu vaccine certificate (if applicable)
☐	Pension card (if applicable)
☐	DVA card (if applicable)
☐	Executive power of attorney
☐	Enduring power of guardianship

Please ensure:	
☐	All clothing is labeled with residents name.
☐	You bring coat hangers & any personal items you want to decorate the room (photos, artwork etc).
☐	We kindly ask you do not bring any furniture as this may clutter the room. We do however allow you to bring an armchair or recliner chair. Please tick here ☐ if you wish to bring one in with you
☐	Medications are packed in blister packs along with a copy of the most recent medication profile and nurses signing sheets.
☐	Visitors provide proof of COVIDI9 and Flu vaccination. Please provide hard copy to reception or email to the correct facility below Leederville - recpetion@rosewood.org.au | West Perth - reception.wp@rosewood.org.au