	PATIENT / RESIDENT IDENTITY FORM
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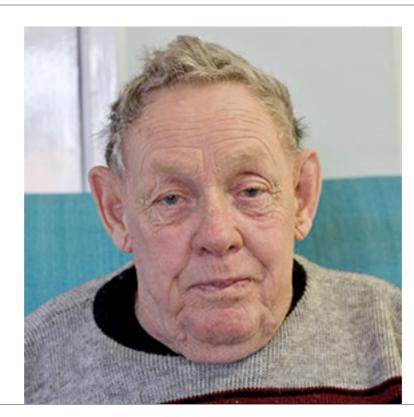
0	LICODITAL / EACH IT/
Sunshine Village	HOSPITAL / FACILITY

PATIENT/ RESIDENT IDENTITY FORM

WARD:	4A	
DOCTOR:	Louise Marsh	

Clinician Name

	Please use ID Label or block p	orint
	SURNAME	URN
	JONES	A2435498
ı	GIVEN NAMES	
ı		
ı	MALCOLM	
	D.O.B.	GENDER
	4/11/55	М
ı	ADDRESS	
	5555 DONOVAN ST, AUGUSTA, WA 6290	



Date Photo Taken: 1/2/YYYY	Renewal Date: 1/2/	/YYY
Photograph to be renewed every 12 months to retain cu	rrency.	
Preferred Name: MALCOLM		
Ward:4A		
Height: <u>168cm</u>	Weight:82kg	
Hair Colour: Light grey	Eye Colour: Blue	
Distinguishing Features: Nil		
Code Alert: ☐ Yes No Aggre	ssive:	
CONSENT TO PHOTO		
□ Patient/Resident □ NOK/Guardian		
MALCOLM JONES	Malcolm Jones	2/9/YYYY
Consent Person's Name	Signature	Date
CLINICIAN SIGN-OFF	<u> </u>	
Louise Marsh	4 Marsh 2/9/YYYY	10:35

Signature and Designation

Date