

Care Home Patient Initial Assessment

Name:

DOB:

1. **Nursing / Residential / Dementia Nursing / Dementia Residential** *(please circle)*

2. **Long stay / Short stay** *(please circle)*

3. Next of Kin

Name:

Relationship:

Contact Number:

4. Has a power of attorney been appointed? **Y / N** *(please circle)*

If yes please state:

Health

Name:

Contact Number:

Finance

Name:

Contact Number:

5. Do Not Resuscitate order (DNAR) in place? **Y / N** *(please circle)*

6. Advance Directive? **Y / N** *(please circle)*

7. DOLS in place?

DOLS applied for?

8. Safe guarding concern **Y / N** *(please circle)*

9. Mobility

Fully mobile

Uses single walking stick

Uses Zimmer frame

Dependent in wheelchair

Transfers using hoist

Bed ridden

10. Vision

Normal vision **left / right / bilateral** *(please circle)*

Poor vision **left / right / bilateral** *(please circle)*

11. Hearing

Normal hearing

Hearing impaired **left / right / bilateral** *(please circle)*

12. Speech impairment **Y / N** (please circle)

If yes, please explain the difficulty in speech:

e.g. Difficulty interpreting/responding to verbal/non-verbal communication

13. Dressing

Independent with dressing

Needs help with dressing

Fully dependent for dressing

14. Sleep

Good sleep pattern

Poor sleep

15. Swallowing

Swallowing normal

Difficulty in swallowing solids

Difficulties in swallowing liquids

16. Bowels

Continent

Incontinent

17. Bladder

Continent

Incontinent

18. Alcohol

Non-drinker

Alcohol consumption Units per day

19. Tobacco

Ex-smoker

Current non-smoker

Cigarettes smoked per day

20. Weight kg

Height cm

Has there been a recent weight loss? If yes MUST score **0 1 2** (please circle)

Blood pressure

/ mmHG

Pulse

/min

Blood Oxygen Saturation

%

21. Urine

WBC

Nitrites

Protein

Blood

Glucose

22. Allergies (please list below)

23. Acute Issues

Please list any apt issues that you would like the GP to address during the first appointment:

24. Attachments (scanned copies or photocopies)

- Mandatory
 - Registration form fully filled and signed
 - Copy of MAR chart
 - Recent discharge summary if admitted from hospital/care facility
 - DNAR copy
 - Copy of Power of attorney document

- Where appropriate
 - Advance Directive document
 - Safeguarding report