

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