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| **Information Prior to Admission** |

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| ***Personal Information*** |
| **Name:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Age:** |  |
| **NI Number:** |  |
| **NHS Number:** |  |
| **Next of kin:** | Relationship:Address:Telephone No: Mobile Telephone No: |

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| ***Social Worker – Care Manager Details*** |
| **Name of Social Worker:** |  |
| **Referring Authority:** |  |
| **Address:** |  |
| **Telephone No:** |  |
| **Fax No:** |  |
| **Email:** |  |
| **Date of Assessment:** |  |
| **Signature of Assessor:** |  |

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| ***Present Accommodation*** |
| How long have you lived in your current accommodation? |
| What care and support are you currently receiving? |
| How do you feel about your current accommodation and are you having any problems? |

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| ***Required Accommodation*** |
| Please detail your accommodation needs and requirements: |
| Ground floor accommodation? | **YES/NO** |
| Wheelchair access? | **YES/NO** |
| Special bathing or showering facilities? | **YES/NO** |
| Do you need any other special considerations, such as any other equipment or adaptations that you may require? *If* ***YES*** *please give details:* | **YES/NO** |

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| ***Current Doctor***  |
| **Name of Doctor:** |  |
| **Name of practice:** |  |
| **Address:** |  |
| **Telephone No:** |  **Fax No** |

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| ***Current Consultant***  |
| **Name of Consultant:** |  |
| **Name of Hospital:** |  |
| **Address:** |  |
| **Telephone No:** |  |
| **Fax No:** |  |

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| ***Physical Health***  |
| Do you have anyphysical health problems that you are currently being treated for? *If* ***YES*** *please give details.* | **YES/NO** |
| Do you have a medical diagnosis?*If* ***YES*** *please give details.* | **YES/NO** |
| When was the diagnosis made? |
| What treatment are you having for this condition and have you been prescribed medication? *Please give details.* |
| Have you ever been admitted into hospital for a physical health condition?*If* ***YES*** *please give details.* | **YES/NO** |
| Have you ever been colonised or infected with MRSA?*If* ***YES*** *please give details.*When did you last have an eye test?*Date of last test: Do you want an eye test?* | **YES/NO** |
| When did you last visit a dentist for treatment or a consultation?*Date of last visit: Do you want a check-up?* |
| Do you have a hearing impairment?*If* ***YES*** *please give details.* | **YES/NO** |
| When did you last visit a podiatrist for treatment or a consultation?*Date of last visit: Do you want a check-up?* | **YES/NO** |
| Do you have any special dietary needs due to a physical health need?*If* ***YES*** *please give details.* | **YES/NO** |
| Do you have any other physical health needs which may affect your accommodation needs?*If* ***YES*** *please give details.* | **YES/NO** |
| ***Mental Health***  |
| Do you have anymental health problems that you are currently being treated for?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you have a mental health diagnosis?*If* ***YES*** *please give details.* | **YES/NO** |
| When was the diagnosis made? |  |
| What treatment are you having for this condition and have you been prescribed medication? Please give details. |
| Do you suffer from any side-effects of prescribed medication?*If* ***YES*** *please give details.*  | **YES/NO** |
| Have you ever been admitted into hospital due to deterioration in mental health?*If* ***YES*** *please give details.*Have you ever been subject Deprivation of Liberty Authorisation (DOLs)?*If* ***YES*** *please give details.* | **YES/NO****YES/NO** |
| Have you ever had any mental health problems in the past that no longer affect you? If ***YES*** *please give details.* | **YES/NO** |
| Is there anything that can trigger your mental health problems, such as alcohol, drugs, stress, noise, other people?*If* ***YES*** *please give details.* | **YES/NO** |
| Do you have any problems managing and coping with stress and certain situations?*If* ***YES*** *please give details.* | **YES/NO** |
| ***Advanced Care Planning*** |  |
| Have you discussed advanced care planning?*If* ***YES*** *please give details.*Do you have a Lasting Power of Attorney?*if* ***YES*** *please give details:*Have you made an advanced decision to refuse treatment:Do you have any Preferred priorities for care:Have you made any wishes and preferences regarding future care needs in relation to deteriorating health needs and end of life care: |
| Do you self-administer all or part of your prescribed medication?*If* ***YES*** *please give details.* | **YES/NO** |
| Is any of your prescribed medication administered by a qualified nurse, such as a CPN?*If* ***YES*** *please give details.* | **YES/NO** |
| Do you take your prescribed medication regularly? | **YES/NO** |
| Do you need support when taking your prescribed medication?*If* ***YES*** *please give details.* | **YES/NO** |
| Do you suffer from or have you ever suffered from any side effects?*If* ***YES*** *please give details.* | **YES/NO** |
| ***Alcohol*** |
| Do you consider your alcohol use to be a problem?*If* ***YES*** *please give details and state what difficulties you experience:* | **YES/NO** |
| How long have you had problems with alcohol and been alcohol dependant? |  |
| What do you drink? |
| How much alcohol do you drink? |
| How often do you drink alcohol? |
| Do you suffer from alcohol withdrawal and if so, what symptoms do you have when withdrawing?*If* ***YES*** *please give details.* | **YES/NO** |
| Have you ever undergone a detoxification programme or reduction programme?*If* ***YES*** *please give details:* | **YES/NO** |
| Have you ever had a period of abstinence from alcohol?*If* ***YES*** *please give details:* | **YES/NO** |
| Have you ever had any involvement or support from alcohol agencies, such as Community Alcohol Team, Alcoholics Anonymous, Brian Hore Unit or other agencies?*If* ***YES*** *please give details:* | **YES/NO** |
| What is your current drinking pattern?*Please give details:* |
| ***Communication Skills*** |
| Are you able to read and write?*Please give details:* | **YES/NO** |
| If NO, would you be interested in literacy/remedial classes?*Please give details:* |
| Do you find using the telephone?*Please give details:* | **YES/NO** |
| Do you have difficulty in communicating verbally and do you use any communication aids?*If* ***YES*** *please give details:* | **YES/NO** |
| ***Mobility*** |
| Do you have mobility problems?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you use or need any special aids or adaptations to assist you with your mobility?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you receive or have you ever received DLA mobility component?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you have or would you possibly qualify for a bus pass? | **YES/NO** |
| Do you access community amenities and facilities?*If* ***YES*** *please give details:* | **YES/NO** |
| Would you like to access community facilities with support?*If* ***YES*** *please give details:* | **YES/NO** |
| Will an Occupational Therapist assessment be needed on admission?*If* ***YES*** *please give details:* | **YES/NO** |
| Have you ever suffered from falls and sustained injury when you have fallen?*If* ***YES*** *please give details:* | **YES/NO** |
| ***Therapeutic Activities, Leisure and Hobbies*** |
| How do you like to relax:*Please give details:* |
| How do you spend your day?*(e.g. games, activities, day centres, education, sports, clubs, college, reading, TV, radio) –* *Please give details:* |
| Do you have friends locally that you still have contact with on a regular basis?*If* ***YES*** *please give details:* | **YES/NO** |
| Are there any educational or therapeutic activities that you are interested in?*If* ***YES*** *please give details:* | **YES/NO** |
| ***Friends & Family*** |
| Do you have family?*Please give details:* | **YES/NO** |
| Do you have contact with any members of your family and if so, how often?*If* ***YES*** *please give details:* | **YES/NO** |
| Would you like to have more contact with your family?*If* ***YES****, is there a reason why you cannot do this.* | **YES/NO** |
| Do you have a next of kin or other person that you want us to contact in the event of an emergency or accident? *Please give details:**Name:**Relationship:**Address:**Telephone No:* | **YES/NO** |
| Are there any safeguarding concerns or issues relating to family or friends contact that may need to be considered? *If* ***YES*** *please give details:* | **YES/NO** |
| ***Culture & Religion*** |
| What is your religious denomination? |
| Do you need any support with accessing religious or cultural services or organisations?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you have any specific dietary needs because of your cultural or religious needs?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you have any other religious or cultural needs that we need to be aware of?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you need any support with translation?  *If* ***YES*** *please give details:* | **YES/NO** |
| ***Self-Help Skills*** |
| Do you need any support with personal hygiene? *If* ***YES*** *please give details:*(e.g. washing, bathing, shaving, continence, etc). | **YES/NO** |
| Do you need support with using public or other transport?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you need support with claiming benefits? What benefits do you receive?*If* ***YES*** *please give details:* | **YES/NO** |
| Do you need support with managing your finances?*If* ***YES*** *please give details:* | **YES/NO** |
| Have you got any current debts, loans or other bills to pay?*If* ***YES*** *please give details:* | **YES/NO** |
| Can you cook and if so, what food do you cook?*If* ***YES*** *please give details:*Do you have any knowledge of healthy eating?*Please give details:* | **YES/NO** |
| Do you need support to do your laundry?Do you have any problems with your memory or cognition that affect your self-help skills?*If* ***YES*** *please give details:* | **YES/NO****YES/NO** |
| Do you need have any difficulty in accessing local services? (e.g. making and attending healthcare appointments).*If* ***YES*** *please give details:* | **YES/NO** |
| Do you have any specific problems with managing your daily living activities and are there any areas that you need support with?*If* ***YES*** *please give details:* | **YES/NO** |
| ***Social Skills*** |
| **(To be completed by assessor)** | **None** | **Poor** | **Average** | **Good** |
| * ***Relationship with staff***
 |  |  |  |  |
| * ***Relationship with other residents***
 |  |  |  |  |
| * ***Relationship with family***
 |  |  |  |  |
| * ***Relationship with figures in authority***
 |  |  |  |  |
| * ***Appropriate behaviour outside the home***
 |  |  |  |  |
| * ***Ability to travel independently***
 |  |  |  |  |
| * ***Use of home facilities***
 |  |  |  |  |
| * ***Level of insight into condition and needs***
 |  |  |  |  |
| * ***Openness to counselling/therapy***
 |  |  |  |  |
| * ***Use of community facilities***
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| * ***Verbal communication***
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| ***Behavioral Issues*** |
| Verbal aggression towards staff?*If* ***YES*** *please give details:* | **YES/NO** |
| Verbal aggression towards residents?*If* ***YES*** *please give details:* | **YES/NO** |
| Physical aggression towards staff?*If* ***YES*** *please give details:* | **YES/NO** |
| Physical aggression towards residents?*If* ***YES*** *please give details:* | **YES/NO** |
| Any history of self-harm?*If* ***YES*** *please give details:* | **YES/NO** |
| Any history of being sexually inappropriate, either verbal or physical?*If* ***YES*** *please give details:* | **YES/NO** |
| Any history of criminal activity, detailing any convictions?*If* ***YES*** *please give details:* | **YES/NO** |
| Any history of obsessional behaviour, OCD presentation?*If* ***YES*** *please give details:* | **YES/NO** |
| Any behaviour that could be challenging and need additional support from staff?*If* ***YES*** *please give details:* | **YES/NO** |
| ***Staff Support Required*** |
| ***Please detail level of support needed; support throughout the day, minimal support, daily monitoring and any other support requirements.*** |
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| **Risk Assessment** |

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| ***Personal Information*** |
| **Name:** |  |
| **Address:** |  |
| **Date of birth:** |  |
| **Date:** |  |
| **Social Worker:** |  |
| **Other Professionals Involved:** |  |
| **Diagnosis and medical conditions:** |  |

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| ***Identified risks to self:*** | ***Risk Management Plan:*** |
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| ***Identified risks of cross-infection:*** | ***Risk Management Plan:*** |
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| ***MRSA*** | ***HEPATITIS*** | ***C-DIFF*** | ***ANY OTHER*** |
| Yes/No | Yes/No | Yes/No | Yes/No |

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| ***Identified risks to others:*** | ***Risk Management Plan:*** |
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| ***Identified risks of vulnerability/exploitation:*** | ***Risk Management Plan:*** |
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| ***Identified risks of self-neglect:*** | ***Risk Management Plan:*** |
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| ***Identified risks when away from home:*** | ***Risk Management Plan:*** |
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| ***Identified risks of taking prescribed medication:*** | ***Risk Management Plan:*** |
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| ***PEEP – Personal Emergency Evacuation Plan*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of smoking:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of alcohol use:*** | ***Risk Management Plan:*** |
|  |  |
| ***Identified risks of falls:*** | ***Risk Management Plan:*** |
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