



Horsfall House

Application Form – Day Centre

Full Name & Title:

Address:

.....

Postcode: Tel. No:

Date of Birth: Email

Marital Status: Religion:

Next of Kin: Relationship to Applicant:

Tel. No: Email:

Other Contact: Tel. No:

Referred by:

Doctor/Surgery: Tel. No:

Will your care be funded? Privately Social Services/NHS

Social Worker Name: Tel. No:

Invoice address if different from service user's:

.....

Preferred Days: Mon Tues Wed Thur Fri Sat

Do you require transport? Yes / No

Please state your past medical history and any existing medical conditions:
.....
.....
.....

Please list all current medication prescribed by your GP and/or homely remedies from the chemist
.....
.....

Please list any allergies to medication or substances:.....
.....

Please answer the following questions as best you can:

Eating and Drinking: Do you need help cutting up your food?
Do you have any special dietary requirements? (e.g. Diabetic,
Vegetarian, Coeliac)
Do you eat a normal, soft or liquidised diet?.....
Do you need food supplements?.....
Do you have any food allergies?

Passing Urine: Do you have full control?.....
Do you need a pad to promote your continence?.....
Do you require a urethral catheter tube?.....
Do you need reminding to use the toilet?.....

Do your bowels: Work Normally?.....
Let you down from time to time?.....
Need assistance from a nurse or carer?.....
Require a pad due to leakages?.....

Bathing: Do you require a bath?
Do you need supervision? If yes, how many carers assist?.....

Dressing & Undressing: Can you manage independently?.....
Do you need help? If yes, how many carers assist?.....

Mobility: Can you get up and walk on your own?.....
Do you need some help?.....
Do you use any of the following mobility aids?

- Zimmer Frame
- Sticks
- Stand Aids
- Hoist
- Wheelchair
- Wheelchair – outside use only

Do you have any special cushions on your chair to sit on?.....

Can you see: Well / with difficulty / not at all?.....
Do you wear spectacles?

Can you hear: Normally / with a hearing aid?.....

Communication: Do you normally understand what people say?
Can you understand people but with difficulty?
Can you not understand people at all?
Can you express yourself vocally?

Do you become confused: Occasionally / a lot / all the time?

Is your memory: Good / not very good / very impaired?
(short and/or long term)

Do you: Become agitated with your carers?
Ever strike out at anyone?

Please list your pastimes/hobbies/interests:

.....
.....

Any other relevant information:

.....
.....
.....
.....

Do you receive Home Care? Yes/No Who is your Home Care provider?

Would you like to receive information about other Horsfall House services? Home Care

Nursing Home

Signed: Date:

(Print Name)

Relationship to applicant if signed on their behalf:

Please return to: Day Centre, Horsfall House, Windmill Road, Minchinhampton, Glos, GL6 9EY