Application Form
Dr Booth 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 ☐

Do you require transport? Yes / No

Covid -19 vaccinations Date: 1ST ---------- 2ND ---------- 3rd ---------- 4th ----------

Please provide proof of vaccinations.

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

If a client has DNAR, RESPECT or Advance Care Planning -please provide copy for their care system. .

Please list all current medication prescribed by your GP and/or homely remedies from the chemist **(please complete form attached)**

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? ---

Additional Services Bathing Facilities/ hairdresser available by appointment? ---

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 ☐

☐

Do you consent to your photograph being taken for use on our digital care plans? Yes/No

Signed: ---------- Date:----------

(Print Name) ----------

Relationship to applicant if signed on their behalf: ----------

Where did you hear about Horsfall House? ----------

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