Application Form – Nursing Home

Horsfall House is a centre for elderly care, owned and run by the trustees of a local community based charity, providing general nursing care and care for older people with varying degrees of memory loss.

When you apply for admission to the residential part of the centre we would like to initiate certain simple formalities to assess your suitability for the centre and try to gauge ways in which we can help in the period whilst you are waiting for a vacancy.

Apart from the residential units we provide care in the client's own home, meals on wheels and a day centre, any or all of which may be helpful to you.

We include a short questionnaire to assist us to focus on your particular needs. It would help us if you or one of your family or carers could fill it in. If there is a problem, one of our qualified staff could go through it with you. If you are unable to meet the fees, then you should have your needs assessed by a social worker who will organise a plan for care with you and report directly to us regarding your needs and funding support. Your doctor, district nurse or mental health worker could advise you on how to arrange this.

Full Name & Title: ____________________

Address: ____________________

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Postcode: ____________ Tel. No: ____________

NHS Number: ____________ National Insurance No: ____________

Marital Status: ____________ Date of Birth: ____________

Next of Kin: ____________ Relationship to Applicant: ____________

Address: ____________________

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Postcode: ____________ Email: ____________

Tel. No: ____________ Mobile: ____________

GP Name & Surgery: ____________ Surgery Tel. No: ____________

Is your GP willing to retain you as their patient when you enter residential care? Yes/No

Will your care be funded: Privately Social Services/NHS

Social Worker Name: ------------------------- Tel. No: --

Do you have any professional help with daily living? Yes/No If yes, is this from:

a) District Nurse
b) A Home Care worker
c) A private helper
d) Day Centre
e) Other

Please tick as appropriate and name the agency that assists you: ----------------------------------

Please answer the following questions as best you can:

Eating and Drinking:

Do you need help getting your meals? --------------------------------

Do you need help cutting up your food? ------------------------------

Do you need help feeding yourself? ----------------------------------

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?---------------------------------------

Approximately how many cups of fluid do you drink per day?----------

Do you need a thickener for your fluids?--------------------------------

Do you have your own teeth or dentures?-----------------------------

Do you have any food allergies?---------------------------------------

What foods/drink do you like/dislike?-----------------------------------

Do you have a good/poor/no appetite?--------------------------------

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?--

Passing Urine:

Do you have full control?---

Do you have impaired control?--

Do you need a pad to promote your continence?------------------------

Do you require a urethral catheter tube?---------------------------------

Bathing/Showering — Can you bath/shower independently? ------------------------------

Do you need supervision? If yes, how many carers assist? ------------

Do you need full help? --

Do you use any bath/shower aids? If yes, please list. ----------------

Dressing & Undressing: — Can you manage independently? ------------------------------------

Do you need help? If yes, how many carers assist? --------------------

Does a carer/nurse have to do it all for you? ---------------------------

Mobility: — Can you get up and walk on your own? ------------------------------

Do you need some help? --

Are you confined to bed or a chair? ------------------------------------

Do you use mobility aids? If yes, please list. ----------------------------

Do you have you any problems which need frequent help from a nurse? E.g. a wound or pressure ulcer, injections, oxygen therapy, nutritional monitoring, catheter, PEG feeding tube

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Do you have any special mattress / cushions on your bed or chair to lie/sit on? -----------------

Do you need any special seating? --

Can you see: — Well? --

With difficulty? --

Not at all? --

Do you wear spectacles? --

Can you hear: — Normally? --

With a hearing aid? --

Not well enough to talk to other people? --------------------------

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 verbally? ----------------------------------

<u>Sleep</u>:	Is your sleep at night -	Very good? -------------------------------
		Reasonable? -------------------------------
		Very disturbed? ----------------------------

Do you need medication to sleep? If yes, please list. ----------------

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What are your normal times for rising and going to bed? ------------

What type of mattress do you prefer? ------------------------------

How many pillows do you prefer? ---------------------------------

Do you use any bedrails for safety in bed? --------------------------

<u>Do you become confused</u>:	Occasionally? ---
	A lot? --
	All the time? ---

<u>Is your memory</u>:	Good? --
(short and/or	Not very good? --
long term)	Very impaired? --

<u>Do you</u>:	Wander? ---
	Have panic or frightened attacks? -------------------------
	Have difficulty thinking of words? --------------------------
	Have no real communication? -----------------------------
	Become agitated with your carers? -------------------------
	Ever strike out at anyone? --------------------------------
	Have any difficulty maintaining your own safety? -------------
	Have difficulty choosing appropriate clothing? ---------------

Do you have any problems with your breathing? If yes, please state the cause:

Do you have any beliefs? Do you practise a religion? ----------------------------

Do you have any specific wishes within a Living Will or Advance Directive?
If yes, please give details:

Do you have a nominated Power of Attorney for 1) Property & Finance 2) Health & Welfare?
If yes, please give details:

Do you have a Deputy appointed by the Court of Protection?
If yes, please give details:

(At time of admission copies of relevant documents are required)

Please list your pastimes/hobbies/interests:

Please list all current medication prescribed by your GP and/or homely remedies from the chemist (please include any natural remedies or supplements)

Please list any allergies to medications or substances:

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

For people with memory problems, please confirm your:
Consultant Psychiatrist/Mental Health Practitioner or Support Service:

Date and nature of memory diagnosis:

Any other relevant information:

If you are presently in hospital, please give details:

Signed: Date:

(Print Name)

Relationship to applicant if signed on their behalf:

Please return to: Nursing Home, Horsfall House, Windmill Road, Minchinhampton, Glos, GL6 9EY