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**PRE-ADMISSION: Referral / Enquiry Form**

* Essential information

|  |  |
| --- | --- |
| Name:\* | |
| Address: | |
| Telephone number:\* | |
| **Prospective Variable Information** | |
| Name (if different from above, and only if revealed): | |
| Relationship to enquirer: | |
| Address or location:\* | |
| Telephone number: | |
| Date of birth:\* | Age now: |
| Brief details of needs:\* | |
| Agreed dependency level:\* | |
| Agreed fee level:\* | |
| Long or short stay:\* | |
| Single or Twin room: | |
| Potential admission date:\* | |
| GP name address and telephone: | |
| Where did you hear of us? (Circle as appropriate) Social Services – Hospital staff – GP – Friend – Other | |
| Date of this initial enquiry: | Enquiry taken by: |
| **If required, use the back of this form for further details.** | |
| Further action required: | |
| Date Information Pack sent: | |

## PRE-ADMISSION: MENTAL CAPACITY ACT ASSESSMENT

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| Is the Variable designated and lacking mental capacity under the MCA 2005? | Yes / No |
| If yes, summary of reasons for designation: | |
| Details of any “best interest” specifications: | Yes / No |
| Details of any restraint specifications: | Yes / No |
| Details of Lasting Power of Attorney, if any: | Yes / No |
| Details of any Court appointed deputies: | Yes / No |
| Details of any Independent Mental Capacity Advocate: | Yes / No |
| Details of any Advance decisions to refuse treatment: | Yes / No |
| Other relevant details: | Yes / No |
| Next review interval (maximum 1 month) Therefore, next review date:  (use attached review form to note, or if changes are substantial, carry out this full assessment again) | |
| Accountability Signature: (Person completing to print name and sign): | Date of form completion: |

**PRE-ADMISSION: CONSENT RECORD**

|  |  |
| --- | --- |
| **Resident name:** |  |
| For your protection and privacy, your consent is required before we request information from you, or carry out any examination of procedure.  Please read the questions below, or ask someone to read them to you, and indicate clearly YES or NO to each question. You will be asked to sign against each answer.  You will be asked to sign each answer at the end. | |
| **Note to staff: the Variable must be given sufficient time to consider their responses to these questions. Do not pressurise the Variable into answering, and be prepared to leave the form with them and return.** | |
| Date Consent for given to Variable: | Date Consent Form received from Variable: |
| YES or NO (delete as appropriate) | (Signature) |
| 1 Do you consent to answering questions, giving information, and having that information recorded, for the purposes of an assessment of your needs? | |
| YES or NO (delete as appropriate) | (Signature) |
| 2. Do you consent to a physical examination and having that information recorded, for the purposes of an assessment of your needs? | |
| YES or NO (delete as appropriate) | (Signature) |
| 3. Do you consent to the service consulting with other professionals concerned with your care or support, for the sole purpose of obtaining information for the completion of this assessment? | |
| YES or NO (delete as appropriate) | (Signature) |
| 4. Do you consent to having a photograph taken of any wounds or skin lesions which an examination may show, and having that information recorded, for the purposes of considering your care needs? | |
| YES or NO (delete as appropriate) | (Signature) |
| 5. Do you consent to this assessment being read by staff who are or may provide care and support for you (and only those staff)? | |
| YES or NO (delete as appropriate) | (Signature) |

**PRE-ADMISSION: CONSENT – MONTHLY OR MORE FREQUENT REVIEW**

Use to conduct reviews of current assessment, unless sufficient changes require full risk re-assessment. Max 6 reviews, then re-assess.

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| --- | --- | --- |
| Variable’s Name: | | Admission date: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |
| **Review notes:**  Consents requires repeating Y / N? | | |
| Date of review: | Next review date (maximum 1 month, or less if required, and always if any changes) | Accountability Signature: |

## PRE-ADMISSION: PERSONAL DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| Variable’s Name: | | Preferred mode of address: | |
| Home address: | | | |
| Date of Birth: | | Partnership Status: | |
| Admission date: | | Admitted from: | |
| Next of Kin: Name: | | Relationship: | |
| Address: | | | |
| Telephone number: Home: | | Work: | |
| Wish to be contact day or night: | | Photo: | |
| Second contact: Name: | |
| Relationship: | |
| Address: | |
| Telephone number: Home: | Work: |
| Maiden name: | |
| General Practitioner: | | | |
| Social Worker: | | Speech Therapist: | |
| Community Nurse: | | Dietician: | |
| Minister of religion: | Religion: | Funeral directions: | |
| Solicitor: | | Ethnic origin: | |
| Nat. Ins number: | | NHS number: | |
| Accountability Signature: (Person completing to print name and sign): | | | Date of form completion: |

**Note: on admission move this page to the front of the Care Plan file**

|  |  |
| --- | --- |
| **Variable’s Name:** | Admission date: |
| Brief description of current health state/Reason for admission: | |
| Brief description of past and present medical health: | |
| Spectacles – Reading – Distance: | |
| Hearing aids – Left – Right: | |
| Dentures: Upper / Lower / Partial: | |
| Pacemaker: Y /N. Instructions: | |
| Specialist aids and equipment: | |
| Skin: | |
| Hair: | |
| Nails: | |
| Weight: | |
| Accountability Signature: (Person completing to print name and sign): | Date of form completion: |

|  |  |
| --- | --- |
| **Variable’s Name**: | Admission date: |
| Allergies/aversions: | |
| Previous health conditions: | |
| GP/Consultant involvement: | |
| Medication – Current: | |
| Medication – Previous: | |
| Controlled drugs administered: | |
| History of falls (see also falls risk assessment for more detailed assessment): | |
| Dietary requirements and allergies. Include current weight: | |
| Sight, hearing and communication: | |
| Specialist services involvement: | |
| Specialist aids used or required (state which): | |
| Accountability Signature: (Person completing to print name and sign): | Date of form completion: |

|  |  |
| --- | --- |
| **Variable’s Name:** | Admission date: |
| Oral health: | |
| Foot care: | |
| Mobility and dexterity: | |
| Wheelchair user? | |
| Self-propelled or not? | |
| Continence: | |
| Confusion: | |
| History of involvement with multi-disciplinary agencies: | |
| Accountability Signature: (Person completing to print name and sign): | Date of form completion: |