NURSING HOME PRE-ADMISSION ASSESSMENT FORM

<table>
<tr><td>Clients Name:</td><td>NHS No

AIS No (if applicable).</td><td>DOB:</td></tr>
<tr><td rowspan="2">Home Address</td><td colspan="2">NOK Contact Details

Telephone:

Relationship:</td></tr>
<tr><td colspan="2">Other contact:</td></tr>
<tr><td>Marital status</td><td colspan="2">Ethnic origin</td></tr>
<tr><td>Religion</td><td colspan="2">Date of Referral:</td></tr>
<tr><td>GP Details and Address</td><td colspan="2">Care Home Manager Name:

Has capacity to determine discharge destination Yes No

DOLS In place To be applied for</td></tr>
<tr><td>Current location

Admission date</td><td colspan="2">Advance decision or care plan in place Yes/No

DNACPR Form: Yes/No

Last Power of Attorney: Finance Health and Welfare
Copy on file</td></tr>
<tr><td colspan="3">Medical History:</td></tr>
</table>

Reason for Admission to Hospital **Recent tests and results:**	**Reason for Admission to Unit**

LIKES/DISLIKES -WHAT IS IMPORTANT TO ME		
PSYCHOLOGICAL, **SPIRITUAL,** **CULTURAL & SOCIAL INTEREST**		

HEALTH AND WELL BEING		
MEDICATION	Allergies Yes/No	
	Compliant Non-Compliant Covert?	
	Self administering Assistance Prompting Full Support	
	Swallowing difficulty with tablets Yes No	
	Format of medication Tablets Liquids Patch	
	Aids used (please state):	
	Consent to be given Yes No	
	Current medication / Doses	**Instructions / times**
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MEDICATION cont'd		
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Comments / Action		

PAIN	Pain free Acute pain Chronic pain	
	Location of pain	
	Analgesia	
	Other actions to relieve pain:	
Comments / Action		

COMMUNICATION / MENTAL HEALTH		
MEMORY & COGNITION	No memory problems Short term memory loss Long term memory loss	
Wears glasses Yes No Reading	Occasionally forgetful/needs prompting Significant and / or cognitive impairment	

Hearing aid Left ear Right ear	Disorientated Wanders	
	Able to use call bell Yes No	
	Understands spoken word Yes No Can respond appropriately Yes No	
	Orientated in time and place Yes No	
	Can make day to day decisions Yes No Mental Capacity Assessment completed Yes	
	Known to Mental Health Services Yes / No	
	Contact details:	
Comments / Action		

TEMPERAMENT / MOOD / CO-OPERATION	Even tempered and consistent Occasionally agitated easily resolved	
	Regularly agitated easily resolved Constantly agitated or requires intensive intervention	
	Challenging behaviour? (please specify)	
	Depression Anxiety Disinhibited behaviour Self harm	
	Actively co-operative Requires encouragement to cooperate	
	Declines / resists assistance	
Comments / Action		
MOBILITY	Independent indoors Independent outdoors Immobile	
	Assistance to mobilise (please state):	
	Uses aids to mobilise (please state):	
	Limb or Joint Contractures Yes No Hand L/R	OT/Physio Advice

	Elbow L/R Knees L/R Other	Plans on discharge
	Prosthesis	
	Wheelchair user Outside Inside No	
	History of falls Yes No Date of Last Fall	
Comments / Action		

TRANSFERS (bed / chair / toilet)	Independent Needs supervision Assistance of 1 Assistance of 2	
	Unable to Transfer	
	Aids used (please state):	
Comments / Action		
NUTRITION	Allergies to food Yes/No (please state)	
LIKES	Swallowing difficulty Yes No	SALT Assessment Yes No
	MUST Score LOW MED HIGH	Weight Recent weight loss Yes No
	BMI	Height

DISLIKES	Drinks Well Yes No	Eats Well Yes No
	Eats Independently Assistance required Prompting required Specialist equipment (please state)	
	Dietary restriction and reason? (please state):	
	Normal Diet Soft/ Moist Diet Pureed Diet	
	Thin fluids Thickened Fluids Stage I II III	
	PEG feed	
	Regime	
Comments / Action		

MY PERSONAL CARE	
DRESSING	Independent Assistance of 1 person Assistance of 2 people Totally Dependent
Comments / Action	
HYGIENE	Independent Assistance of 1 person Assistance of 2 people
	Totally dependent Bath Shower Bedbath
	Support required with: Nail care Foot care Hair care
Comments / Action	
ORAL HYGIENE	Independent Requires assistance

	Own Teeth Partial plate Condition of teeth
	Dentures Top Bottom Date last saw dentist?
Comments / Action	Is referral to community dentist required? Yes No

CONTINENCE CARE	Fully continent Occasional incontinence
	Incontinent of Urine Faeces Both
	Prone to Constipation Diarrhoea Loose stools UTI's
	Stoma
	Catheter Urinary Suprapubic Date last changed Catheter type Size
	Continence aids used:
Comments / Action	
SKIN CARE	Waterlow / Braden Score
	Pressure areas intact Yes No Pressure mattress required?
	Wound present Yes No Describe / Dressings Infection present Yes No
	Cream: Where used
Comments / Action	**Body Map to be completed on Admission Yes / No**

FOOT CARE	Known to Podiatrist? Yes name No
	Condition of feet
	Is a referral to Podiatrist required? Yes No
Comments / Action	

SLEEP	Sleeps well In bed In chair
	Type of Bed / Chair (please state):
	Can turn self in bed Yes No
	Bed Rails Yes No
	Night sedation (please state):
	Wakes at night - reason
	Night routine:
Comments / Action	
Additional Information or Equipment to be ordered prior to admission	
Action required following assessment: **To include assessors action and any referrals to be made.**	
Summary of nursing needs **(by a registered nurse)**	

NURSING HOME PRE-ADMISSION ASSESSMENT FORM

This Assessment has been completed with the involvement of the following persons:

Assessor Name …….. ..Title: ……

Client Name: …….. .Ward: ……..

Care Manager Name: ……..Office: ……..

Family Member Name: ……. Relationship:……

Carers Name: ……. Relationship: …….

Date……