Care Home Registration Form

To be completed and returned to surgery with registration paperwork

 Patient /carers wishes (Planning Future Care Questionnaire) form

 Discharge letter /social work forms including medication list

 Adults with incapacity – if completed

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| Name |  | DOB | |  | |
| Name of Next of Kin/carer/worker and relationship to  resident |  | NOK address telephone number Mobile | |  | |
| Date of admission |  | Admitted from home/  hospital | |  | |
| Welfare guardian / Power of Attorney | Yes /No  Name of guardian: | Adults with incapacity certificate | | Yes/No  Requires assessment | |
| Compulsory treatment order | Yes/No | DNACPR in place | | Yes/No  Requires assessment | |
| Patient carer/wishes | Future Care Planning questions discussed with patient/relatives Yes/No  Date………………………………… | | | | |
| Mobility | Independent Walking aids Needs assistance Bed and chair bound Bedbound | | | | |
| Continence | Continent Urinary incontinence-wears pads/ catheter in situ Faecal incontinence | | | | |
| Cognition | No impairment Some confusion 1-2 words only No meaningful interaction | | | | |
| Communication | Speaks clearly Speech difficult to understand Unable to communicate verbally | | | | |
| Measurements | Weight | | Height | | BMI |
| Smoking status | Non-smoker / Ex- Smoker/ Current smoker:  Cigarettes per day. | | Blood Pressure | |  |
| Consent for sharing information with Out of Hours Doctors Yes/No | | | | | |