**Care Home Questionnaire**

|  |  |
| --- | --- |
| **Patient First Name** |  |
| **Patient Surname** |  |
| **Patient Date of Birth** |  |
| **Registration Type** | Choose an item. |
| **Name of Care / Nursing Home** | Choose an item. |
| **Name of person completing the form** |  |
| **Main language spoken** |  |
| **Does the patient require a face to face visit** | Choose an item. |
| **Needs discussing at next available MDT** | Choose an item. |
| **Medication Required** |  |
| **Medication Review Required** | Choose an item. |
| **Has the patient recently been into Hospital** | Choose an item. |
| **If yes, was it planned or unplanned** | Choose an item. |
| **Reason for admission** |  |
| **DNAR in place** | Choose an item. |
| **ReSPECT in place** | Choose an item. |
| **Has mental capacity to give consent** | Choose an item. |
| **Has mental capacity to decline consent** | Choose an item. |
| **Lacks capacity** | Choose an item. |
| **Behaviour** | [ ]  Challenging[ ]  Inappropriate[ ]  Problem[ ]  Manageable[ ]  Difficult to manage |
| **Continence** | [ ]  Continent[ ]  At risk[ ]  Urinary incontinence[ ]  Incontinence of faeces[ ]  Double incontinent |
| **Falls** | [ ]  Low risk[ ]  At risk[ ]  High Risk[ ]  Does not fall[ ]  Infrequent[ ]  Recurrent[ ]  Risk assessment referral made[ ]  Risk assessment referral refused |
| **Mobility** | [ ]  Full[ ]  Reduced[ ]  Confined to chair[ ]  Bed - ridden |
| **Nutrition** | [ ]  Well nourished[ ]  Nutritionally compromised[ ]  Undernourished[ ]  Nutritional assessment |
| **Pain** | [ ]  None[ ]  Acute[ ]  Chronic[ ]  Intermittent |
| **Personal care** | [ ]  Fully able[ ]  Has difficulty[ ]  Unable |
| **Communication** | [ ]  Has communication need[ ]  Does not have communication need[ ]  Contact required by (email / letter / text / carer / telephone interpreter) |
| **Next of Kin** |
| **Full Name** |  |
| **Contact Number** |  |
| **Address** |  |