## RESIDENT PRE ADMISSION ASSSESSMENT

**Residents Name:** ________________________________________**Age**__________________

**D.O.B**______________________________**AIS Number**_________________________________

**Social Worker / Care Manager:** ____________________________________________________

**Contact Number**________________________________________________________________

**Nursing Assessment receivedYES / NO.**
**Evidence of Consent to share YES/NO .**
**Continuing Health Care Assessment YES / NO**
**Transfer of care form complete if appropriate YES/NO**

**Residents home address**__________________________________________________________

_________________________________________________**Post Code**______________________

**Residents current address / placement** ____________________________________________

_________________________________________________**Post Code**______________________

**Telephone No**___________________________________

**Ethnicity**_____________________________**Marital Status:**_____________________________

**Former occupation** _______________________________________________________________

**Next of Kin** _____________________________________________________________________

**Relationship**_____________________________________________________________________

**Address** _________________________________________________________________________

_________________________________________________**Post code**______________________

**Telephone No**____________________________________________________________________

**Emergency Contact**_______________________________________________________________

**Telephone number**_______________________________________________________

**Enduring / Lasting Power of Attorney in place YES / NO (copy needed)**
**Health and Welfare yes/no Finances yes/no**

**Names**__________________________________________________________________________

**Contact details**____________________________________________________

**Guardianship?** ____________________________________________________

**Present GP** ____________________________________________________

**Surgery Address**____________________________________________________

**Telephone Number**____________________________________________________

**Need to register with local GP ?** **YES** ☐ **NO** ☐

**Known Allergies**____________________________________________________

**Reasons for admission into Home/Unit**____________________________________________________

____________________________________________________

____________________________________________________

**Residents awareness / understanding of admission**____________________________________________________

____________________________________________________

**Other relevant information**

____________________________________________________

____________________________________________________

## ACTIVITIES OF DAILY LIVING

### 1.Safety.

**History of falls YES / NO** **Recent Falls YES / NO**

**Date of last Fall**____________________________________________________

**Frequency of Falls**____________________________________________________

**Action Necessary to reduce risk falls** ____________________________________________________

____________________________________________________

**Bed Rails Used at Present YES / NO In fills required YES / NO**

**If yes has consent been granted? YES / NO**

**Wandering Yes/ No & level of assistance required**____________________________________________________

____________________________________________________

**Smoker Yes / No Support required**____________________________________________________

## 2. Communication.

**Able to verbally express needs YES / NO**

**Able to use call bell YES / NO**

**Languages spoken** ________________________________________________

**Method for effective communication**________________________________________

_______________________________________________________________

**Hearing** ______________________**Aids required YES / NO R / L ear**

**Eye sight** ___________________________ **Glasses required YES / NO**

**Support required**______________________________________________

_______________________________________________________________

## 3. Behaviours and Cognition.

**Understands spoken word Yes / NO**

**Is able to respond appropriately YES / NO**

**Is orientated to time and place YES / NO Give details**__________________________

_______________________________________________________________

_______________________________________________________________

**Is able to make day to day decisions. YES / NO**

**Mental Capacity Assessment about moving into residential care completed YES / NO**

**Identify Behaviours that have occurred recently i.e. challenging, verbal or physical, wandering, tolerance of others** ________________________________

_______________________________________________________________

**Any Triggers to behaviour? i.e. noise, ways of approach, infection, constipation etc**_________________________________________________________

_______________________________________________________________

**Intervention to assist in management of identified behaviours**

_______________________________________________________________

**CPN / Medical / other professional involvement**___________________________
**Contact details**

## 4. Health Medication and Pain.

**Most Recent Diagnosis**___________________________________________________________

___________________________________________________________________________

**Past Medical History** ____________________________________________________

___________________________________________________________________________

**Breathing problems/difficulties**__________________________________________________

**Oxygen Therapy Yes / No Litres / min**_____________________________________________

**Relevant recent Test / Investigation results i.e. Blood, Swab, MRSA, C-Diff.**

___________________________________________________________________________

___________________________________________________________________________

**MEDICATION**

**Self Medicates YES / NO. Has understanding of medication YES / NO.**

**Risk assessment in place for self medication YES / NO.**

**Covert administration of medication YES / NO. Risk assessment in place YES/NO**

**Consent given for administration of medication by staff trained to do so YES / NO.**

**Swallowing difficulties with medication Yes / NO**

**Identify any difficulties with administration of medication and state support required:**

___________________________________________________________________________

___________________________________________________________________________

| MEDICATION | DOSE | ROUTE |
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**Pain management/Assessment:**_____________________________________________

___________________________________________________________________________

## 5. Eating and Drinking.

**Food allergies:**___________________________________________________

**Able to feed self YES / NO** **Independent drinking YES / NO**

**At risk of Choking / Swallowing difficulties Yes / NO**

**SaLT assessment available YES / NO**

**Support/equipment/Thick and easy/ positioning etc required:**_________________________

_______________________________________________________________________________

**Diet: i.e. soft, puree, diabetic, gluten free , low fat etc.**

_______________________________________________________________________________

**Current Appetite**_____________________________________________________

**Current fluid intake**__________________________________________________

**Food supplements YES / NO** ____________________________________________________

**PEG feeding YES / NO**

**PEG details, type of tube, changes of tube, Pump details etc.**__________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Dietician details/contact.**_______________________________________________________

**Weight**________________________________**BMI**___________________________

**Recent weight Loss YES / NO**

**Own teeth / dentures / plates etc.**__________________________________________________

_______________________________________________________________________________

## 6. Continence.

**Continent of urine YES / NO** **Continent of faeces YES / NO**

**Continence products/aids required i.e. pads, commodes, room position etc.**

_______________________________________________________________________________

_______________________________________________________________________________

**Support required i.e. none, prompts,**_______________________________________________

_______________________________________________________________________________

**Usual routine Day** ____________________________________________________________

______________________________________________________________________________

**Usual routine Night**___________________________________________________________

______________________________________________________________________________

**Urinary Catheter in situ Yes / NO Urethral/ Supra Pubic (circle)**

**Catheter type**______________________**date last Changed**______________

**Bladder washouts YES / NO Type/frequency**______________________________________

______________________________________________________________________________

**Colostomy/ Ileostomy (circle) Self managed YES / NO**

**Needs Full assistance to manage YES / NO**

**Management/ Support / equipment required.**

______________________________________________________________________________

______________________________________________________________________________

**History of UTI YES / NO History of Constipation YES / NO**

**Aperients** _____________________________________________________________________

## 7. Personal care and dressing.

**Washing**
**Independently, prompting with supervision, full assistance required (circle)**

**Details of support required/usual routine** _________________________________________

**Prefers Bath, Shower, Strip wash (circle)**

**Support / Equipment required** ___________________________________________________

______________________________________________________________________________

**Nail care, independent / support required**__________________________________________

**Foot care / independent / diabetic / support required**_______________________________

______________________________________________________________________________

**Oral Hygiene, independent, dentures, support required** _____________________________

______________________________________________________________________________

**Hair care, independent, hairdresser, support required**______________________________

______________________________________________________________________

## 8. Skin care.

**Braden score______________High / Medium / Low Risk (circle)**

**Observation of Skin, Dry, Clammy, Oedematous, Discoloured etc ______________________**

**Creams used YES / NO Type / frequency, location.___________________________________**

______________________________________________________________________

**Broken Skin YES / NO**

**Cause i.e. pressure ulcer (grade), skin flap from fall etc. ______________________________**

______________________________________________________________________

**Position of wound/s____________________________________________________________**

______________________________________________________________________

**Infection present YES / NO state swab date and result _______________________________**

______________________________________________________________________

**Treatment i.e. antibiotics etc_____________________________________________________**

**Dressings in use, Type, how often changed__________________________________________**

______________________________________________________________________

**Tissue viability specialist / District Nurse input Yes / NO______________________________**
**Details of visit__________________________________________________________________**

**Contact Details_________________________________________________________________**

______________________________________________________________________

**Present Equipment in use_______________________________________________________**

**Equipment needed for this admission i.e. mattress/cushion___________________________**

**Additional information**___________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## 9. Mobility

**Can walk about the home YES / NO Independent YES / NO support / equipment required to be mobile i.e. Prompting, Zimmer frame**_____________
______________________________________________________________________________
______________________________________________________________________________

**Transfers SELF or State Support required. List equipment required i.e., Hoist, sling type and size, Mo lift, handling belt etc.**
______________________________________________________________________________
______________________________________________________________________________

**Can turn self in bed YES / NO**
**Support and equipment required i.e. Slide sheet.**_____________________________________

______________________________________________________________________________

**Wheel chair user YES / NO**
**OWN Wheelchair YES / NO make serial number, date last service**
______________________________________________________________________________

**Electric wheelchair YES /NO Details of Charging batteries, service/ maintenance details and Contact numbers**_______________________________________________________

______________________________________________________________________________

**Wheel chair cushion in place YES / NO** **Use of Lap Belt YES / NO**

**Assessment in place for use of lap belt i.e. O.T assessment, seating balance, maintain posture**_________________________________________________________________

______________________________________________________________________________

## 10. Social Wellbeing, Activity and Occupation.

**Usual daily routines and activities.** _____________________________________________

**Enjoys social events/ activities**___________________________________________________

______________________________________________________________________________

**Enjoys own company**_________________________________________________________

**Additional information, include hobbies, outside interests etc.**
______________________________________________________________________________
______________________________________________________________________________

## 11. Body Image and Self

**i.e. Makeup, Jewellery, hairdressers etc.**

**Prosthesis type and maintenance details**

**Relevant contact Person/ telephone number**

**Additional information**

**Relationships/ friends to visit etc**

## 12. Sleeping.

**Preferred time to go to bed**

**Preferred time to get up**

**Usual bed time routine**

**Usually wakes in the night YES / NO Support required**

## 13. End of life plans

**Specific requirements / Resident wishes known at this time.**

**Advanced Directives in place Yes / No if yes give details**

**DNACPR status known ? Lilac form with resident YES / NO**

**Religion_________________ Church attended______________________________**

**Equipment**

**Does this client require specific specialist equipment prior to admission e.g. seating, commodes, beds, pressure relieving mattress etc. YES / NO.**

**Please List requirements/equipment (if any) that needs to be in place prior to admission**
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Is referral to O.T necessary YES / NO.**

**From this admission assessment information the estimated level of resident dependency is LOW, MEDIUM, HIGH, (Circle).**

**Additional Information____________________________________________________________**
______________________________________________________________________________
______________________________________________________________________________

**Assessment completed by (Signature)____________________________________________**

**Print name and Designation ________________________________________________________**

**Information obtained from__________________________________________________________**

______________________________________________________________________________

**Signatures ______________________________________________________________________**

______________________________________________________________________________

**Print names and designation_______________________________________________________**

**Signature of resident/representative__________________________________________________**

**Date of assessment_______________________________________________________________**