North Staffordshire Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

NHS
University Hospitals of North Midlands
NHS Trust

Care Home to Hospital

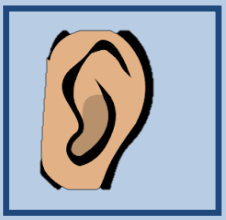
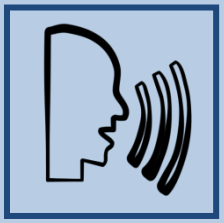
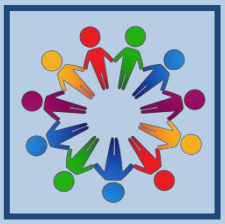
Information About Me

Name:

Care Home Name:

Care Home Telephone Number:



THIS DOCUMENT IS TO STAY WITH THE PATIENT WHILE IN HOSPITAL &
RETURN TO THE CARE HOME WITH THEM

PROUD TO CARE

Name:
Care Home Name:

NHS
University Hospitals of North Midlands
NHS Trust

PATIENTS DETAILS

Full name			
Likes to be addressed as			
Marital Status		**Date of Birth**	

Type of Home *(please circle)*	**Nursing**	**Residential**
Name of Care Home		
Date moved to Care Home		

Address	
Postcode	
Telephone Number	
Fax Number / Email Address	

CONTACTS AT CARE HOME

Home Manager	
Date of review *(due 3 monthly)*	
Transfer of information password *(circle)*	Yes No

NEXT OF KIN

Name	
Relationship	
Address	
Telephone No. Home	
Telephone No. Mobile	

NEXT OF KIN (2ND CONTACT)

Name	
Relationship	
Address	
Telephone No. Home	
Telephone No. Mobile	

MEDICAL HISTORY - *Diagnoses (past and* current *include all known details and dates if possible)*:

Recent admission to hospital in last 6months

Date	Location	Reason

	YES	NO
DNAR/ReSPECT in place *(please ensure sent with patient)*		
I have an Advanced Care Plan / End of Life Plan		
I have a Deprivation of Liberty (DOLS) in Place		
I have a Lasting Power of Attorney-welfare in place		
Name of person appointed		
Telephone number		
I have a Lasting Power of Attorney-finance in place		
Name of person appointed		

GENERAL PRACTITIONER – Name	
Surgery Name	
Address	
Postcode	
Telephone Number	
Fax Number	

ALLERGIES	Yes	No	Not Known
Details:			

WHAT'S NORMAL FOR ME **Date completed / /**

MOBILITY *(circle)*		**EQUIPMENT available in care home(list)**	
Walks Unaided		Walking stick	
Wheelchair		Zimmer Frame / Rollator Frame	
Assistance Required (1 person)		Assistance Required (2 person)	
Unable to walk		Comments:	

AM I AT A RISK OF FALLS? *(circle)*

Yes	No
Date of recent fall(s):	

TRANSFERS IN/OUT OF BED *(circle)*

Unaided	Assistance Required (1 Person)	Hoist	Assistance Required (2 Person)
Bed type: Bed Rails in use Yes No Any equipment used (please list)			
Comments:			

TRANSFERS IN/OUT CHAIR/TOILET*(circle)*

Unaided	Assistance Required (1 Person)	Hoist	Assistance Required (2 Person)
Comments:			

DRESSING/UNDRESSING *(circle)*

Unaided	Minimal Assistance	Full Assistance
Comments:		

SHOWER/BATHING FREQUENCY	*Every_____Days*
HAIR WASHING	*Every_____Days*

Name:
Care Home Name:

University Hospitals of North Midlands NHS Trust

URINARY CONTINENCE *(circle)*		
No concerns	Occasional Accident	Incontinent
Catheterised - *Last date change/when due*		
Comments/Products used:		

FAECAL CONTINENCE *(circle)*			
No concerns	Occasional Accident	Incontinent	Constipation
Comments/Products used:			
My normal bowel movement is *(score & frequency)*:			

VISION *(circle)*				
No concerns			Partially Sighted	Registered Blind
Wears Glasses	Yes	No	Only reading	Continuously
Comments:				

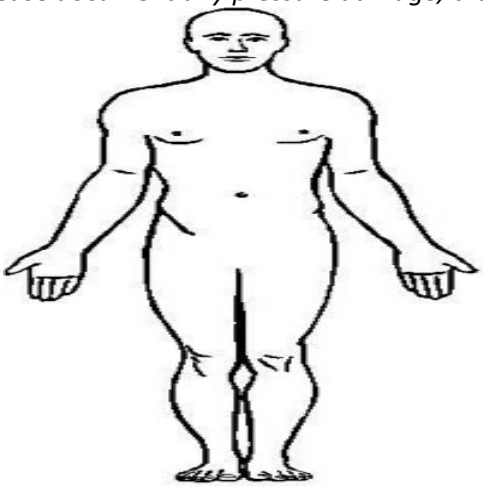
HEARING *(circle)*			**HEARING AID** *(circle)*		
No concerns	Poor	Deaf	Left	Right	Both
Comments:					

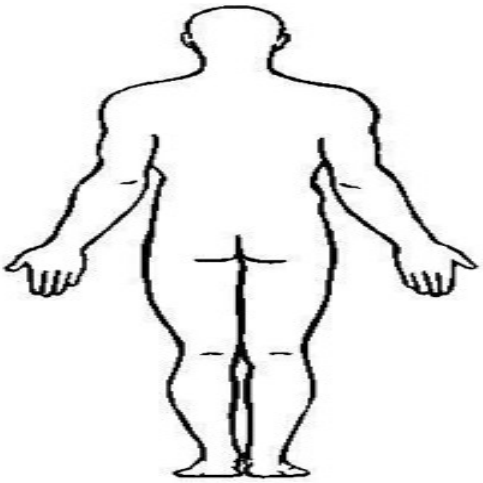
EATING & DRINKING *(circle)*			
Dentures Yes No	Full set	Partial top bottom	
No concerns	Some assistance with food	Full assistance with food	
Modified Drinks		Modified Diet (Specify)	
Weight		Peg/NG Feed	
Comments – *Known to SALT, type of diet, type of fluids etc.:*			

MEMORY/COGNITION*(circle or comment)*		
Diagnosis of Dementia	Other mental illness *(e.g. depression)*	Learning disability
Orientated	Confused at times *(please detail)*	Aggression/challenging behaviour
Comments:		
Level of supervision required *(please detail)*		

SKIN *(circle or comment)*			
Intact	Pressure ulcers	Other wounds/ulcers	
WATERLOW Score		Any dressings used	

Please document any pressure damage, bruising and category below





Name:
Care Home Name:

DISTRICT NURSE *(If known)*		
Yes	No	Name:
Number:		
Details - dressings – type, frequency of change etc.		

INFECTION PREVENTION (MRSA, ESBL, C DIFF) etc		
Am I an infection risk ?	Yes	No
If yes please details:		

SOCIAL HABITS			
Smoking	Yes	No	Details:
Alcohol	Yes	No	Details:
Any others please detail:			

RELIGION/ SPIRITUAL NEEDS

SLEEP	
Usual night sleeping pattern (hours)	
Afternoon rest	
Night needs (e.g. commode, regular toileting…)	

Completed By		**Sign**
Date/Time		

Name:
Care Home Name:

EMERGENCY ATTENDANCE TO HOSPITAL

REASON FOR REFERRAL/GP COMMENTS/ADDITIONAL INFORMATION	OBSERVATIONS **Temp……** **Pulse……** **BP ……** **Resp rate……..** **Blood sugar……**
CURRENT PRESENTATION	
REFERRAL MADE BY	

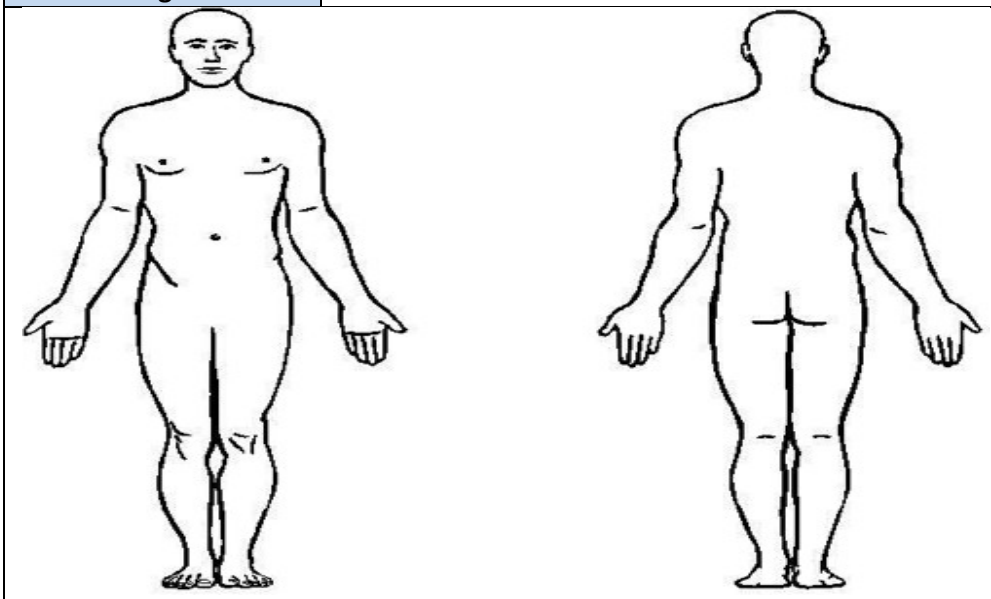
MEDICATION – Please attach a photocopy of **MARS charts** – please ensure that the full text is visible so that we can see the codes at the bottom of the sheet and that the left hand margin is fully included also.

*****PLEASE SEND ONLY THE PATIENTS TIME CRITICAL OR VITAL MEDICATION WITH THEM DO NOT SEND CD's, PRN Meds,blister packs, supplements or creams*****

IF NO CHANGES to medication do they need supply of medication on discharge?	Yes	No

ALLERGIES	Yes	No	Not Known
Details:			

Relative Informed	Yes	No	Which Relative?					
Catheterised - *Last date changed/when due*								
Dentures	Yes	No	Hearing Aid(s)	Yes	No	Glasses	Yes	No
D&V in past 48 hours	Yes	No	Any change in bowel habits					
Recent Weight	Must score							



Please document any bruising / pressure damage and category. *(Only complete if changed from baseline)*

List dressings:

Completed By	
Date/Time	
Sign	