**Care Home Questionnaire**

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| **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** |  |