South Devon Care Services

Pre-Assessment Form

Please return to: sheena.parker@southdevoncareservices.com
Contact: **07704 573281**

Assessment information

Person managing admission / case manager

Place of assessment

People present

Other sources of information used to make assessment

About the person being assessed

Likes to be called

NHS Number

NI Number

Hospital number

Date of Birth

/ /

Marital status

Religion

Address (including Postcode)

Place from which admission will take place Home/Other (please state)

Postcode

Reason for admission to a care home

Next of kin details

Next of Kin

Relationship

Address (including postcode)

Email

Tel Number

Mobile Number

Referral details

Name

Designation

Address (including postcode)

Email

Tel No.

General practitioner details

GP Name

Surgery name, address and postcode

Surgery email

Surgery telephone number

Will a change of doctor/GP be required?

☐ Yes

☐ No

Dentist details

☐ No dentist

Dentist Name

Practice name, address and postcode

Practice email

Practice phone number

Medical information

Medical health history including surgery/any infections: MRSA/C-DIFF/Scabies/other

Details of medical/Health/Specialist diagnose that will require health promotion care plan

Allergies

Mental Health

Please give full details e.g. Psychiatric history: Depression, Suicidal. Cognition, Confusion, Orientation. Physical/Verbal aggression. Motivation. Sundowning. Memory/ Confusion. Behaviour. Delusions. Hallucinations. Clinical anxiety. Antisocial behaviours / mood.

Details of ongoing screening or health checks or health promotion
e.g. Blood Pressure, Phosphorus & Blood tests, Pacemaker. Glaucoma, vision. Hearing. Thyroid. Renal. Diabetes. CVA. Depression. Dementia. Pain. Mobility. Progressive illness. Outstanding appointments. Other

Is a TEP form (Treatment escalation plan) in place?

☐ Yes
☐ No

Emergency requirements/preferences
e.g. Ill health. Minor injury. Major injury / illness – preferences: Hospitalisation / A & E. Who will attend / escort: Key people and contacts. Escort to scheduled appointments. Specialist assistance / support needed.

Current medication

Medication comments

Compliance

Concerns

Administration method
Self/syringe/spoon

Living will / advance directives?

In the event of death are any specific arrangements in place?

Advocacy arrangements

☐ Ability to state one's preferences
☐ Verbal communication
☐ Written communication

☐ Non-verbal communication
☐ Coherent
☐ Ability to retain informed decisions
☐ Good memory
☐ Short term memory impaired
☐ Long term memory impaired
☐ Variable

Description

Is this person giving permission for information about themselves to be passed onto others?
☐ Yes
☐ No
If yes, by whom

Is this person able to make medical/clinical decisions in their own best interest?
☐ Fully
☐ Partially

Are any of the following in place to guide decision making?
select and ask for a copy
☐ Enduring Power of Attorney
☐ Living will
☐ Advanced Care Plan

Are there any care practices restricting this person's freedoms?
☐ Yes
☐ No

Is a DoLs (Deprivation of Liberty) authorisation required?
☐ Yes
☐ No

Give date of any existing DoLs in place
/ /

Give brief detail of any existing DoLs in place

Is this person consenting to be assessed for Residential care?

☐ Yes

☐ No

Is a Best Interest Decision Meeting required prior to admission?

☐ Yes

☐ No

Function details

Any issues with the following? Way of Communicating e.g. Speech – first language / dysphasia. Hearing. Sight – diseases / degeneration. Please add details below.

Do they have…

☐ Aids

☐ Spectacles

☐ Hearing aid

Date of Last eye test/hearing test

/ /

Breathing

e.g. Respiratory problems. Special requirements: O2 / nebulisers.

Eating/Drinking/Nutrition

e.g. Oral health / frequency of dental visits. Appetite / Fluid intake. Sense of smell ? Dietary preferences / requirements. Nutritional needs / Support. Adapted utensils? Allergies? Swallowing issues? SALT assessment. Weight loss issues?

☐ Dentures

☐ Upper

☐ Lower

Height if known (in cm)

Last recorded weight (in kg)

MUST Score if known

Date of last recorded weight

/ /

Elimination (please add details below)

e.g. Continence needs & products. Pain. Night routine for elimination. History – UTI / Constipation. Equipment, skin condition, medication, catheters, access to WC and frequency.

Personal Hygiene

Please state e.g. Preference: Female / male carer. Bath / Shower / Washing. Hair – wash / cut / set. Dressing. Foot Care / finger nails. Oral Hygiene. (? word)Assistance / Supervision. Aids / Prosthesis.

Mobilising

Please add details. e.g. Past injuries, contractures / deformities. Falls history. Standing - aids. Transferring - aids. Walking aids. Wheelchair - routine. Steps / stairs. Balance / footwear. Seating / behaviour.

Maintaining a safe environment

Please add details. e.g. Controlling body temperature. History of falls. Wandering / Absconding. Personal safety and risks. Equipment / aids / adaptations.

Skin Integrity

Skin integrity
Please add details. e.g. Condition of skin: Intact / Broken areas? Dry / paper thin / diseased / tears. Rashes / Blisters. Pressure Injuries / Care(Category / Dressings). Bruises / Swellings. TVN involved ? Nursing requirements: specialist beds or turning?

Waterlow Score if known

Working/Leisure
Please give details. e.g. Social Care. Social/introvert. Past and present employment. Community involvement. Day centres. Hobbies. Family. Spiritual needs. Religious beliefs. Cultural needs. Religious and /or spiritual needs. Preferences. Family involvement in the person's care.

Sleeping
e.g. Position change. Night time routine Medication. Preferences. Nocturnal rising. Equipment / adaptations.

Night time routine
eg, How well do they go to bed? Do they sleep through the night? If not, how many times do they wake and what level of assistance is needed?

Sexuality
e.g. Interest in Appearance: Dressing / make - up. Personal relationships. What makes the person feel loved?

Footcare

Are there any highlighted problems with feet? e.g. Diabetic. Peripheral circulation.

☐ Yes
☐ No

Chiropodist visited?

☐ Yes

☐ No

Frequency of visits

Vaccination status

Covid-19 Vaccination - last vaccination date

/ /

Flu Vaccination - last vaccination date

/ /