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| **Patient Name:** **Ward: or Address** | **DOB:**   |
| **NHS No:** **Swift Number if Council** | **Date of Assessment:**  |
| **GP:**  | **Next of Kin: Please include name and telephone number** |
| **Allergies:** | **DNAR (whilst in acute setting) YES/NO** |
| 1. Behavioural needs are there any problems
2. Does the person require encouragement with day to day tasks.
3. Is there any Dementia to be aware of.
4. Paliative care requirement.
5. General personal care requirement, toileting, medication and nutritional, assisted to bed.
6. Is the person diabetic/ what type.
7. Medication blister pack, boxes, family filled dosset box
8. Does the person have a history of falls
9. Does the person wear glasses
10. Does the person have false teeth or their own or partial.
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|  **Please list the aids available**FrameStick2 sticksCare linkProfile bedOrdinary single or double bedGrab rails in bathroomBed Care – slide sheets, hoistContinence pads |  |
| Psychological needs Depression or other known problems. |  |
| Communication What is the persons spoken language?Can the person communicate?  |  |
| Skin integrity needs |  |
| Continence needsCatheter, stoma, continence careOther concerns |  |
| Respiratory needsHome oxygen, inhalers |  |
| Medication needsPrompting or give |  |
| Altered states of consciousnessDoes the person suffer from epilepsy |  |
| Is there any additional information to be added? |  |

\*Further information attached e.g. body map/med chart/community/ DNAR/

**SIGNED**  **PRINT NAME**

**Designation Date**

**Contact number/email** **services@telopeamsl.com** **– 01234 248969/07702383060**

Please can you supply a photo of the person /patient

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Are you able to offer any background history that may be helpful.

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