

St.Andrew's Medical Centre

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NEW PATIENT FORM FOR RESIDENTS OF CARE HOMES

For Permanent Residents Only

Resident's Details

Name of Care Home:

Resident's First Name:

Resident's Surname :

Title: Mr Mrs Miss Ms Dr Other Male Female

Date of Birth (day/month/year) : Ethnicity:

Date of Admission to care Home: Admitted from Home or Hospital

Registration for GMS1 (purple) attached (for permanent resident) Yes No

Copy of previous GP summary prior to registering attached Yes No

Copy of Hospital Discharge Letter if applicable attached Yes No

Medication

How many days supply of medicines does the new resident have:

How many days supply will the resident need on their first prescription to synchronise with the rest of the homes:

Date next prescription required by:

Resident's Next Of Kin Details

Next of Kin's Name

Relationship to Resident

Next of Kin's Current Address Post Code:

Telephone number: Mobile number:

Has consent been given for medical information to be discussed with Next of Kin or any other persons? Yes No

Does Resident Have a Power of Attorney Yes No

Please provide names

Resident's Wishes

Consent to share Enhanced Summary Care Record Yes No

Does Resident Have Living Will? Yes No or Advanced Care Plan? Yes No

Anticipatory Care wishes known Yes No Care Plan with details attached Yes No

DNAR in Place Yes No

End of Life Wishes Known Yes No Care Plan with details attached Yes No

Resident's Assessment of Needs

Mobility: Independent Walking Aids Needs Assistance Bed & Chair Bound Bedbound

Continence: Continent Urinary Incontinence – wears pads/catheter in-situ Faecal Incontinent

Cognition: No Impairment Some confusion 1-2 words only No meaningful interaction

(If in doubt please do assessment eg MMSE)

Communication: Speaks Clearly Speech Difficult to Understand Unable to communicate Verbally

Hearing Impairment: No Impairment Hearing Difficulties Deaf

Sight Impairment: No Impairment Mild Sight Impairment Significant Sight Impairment Blind

Describe Resident's Mood:

Pressure Area Issues:

Weight:

Height:

Blood Pressure:

Pulse:

Oxygen Sats:

Respiration Rate:

Any Other Issues:

Smoking Status: Non-smoker Ex-smoker Current smoker cigarettes per day

Alcohol Status: Non-drinker Drinks Alcohol How much?

Allergies:

Details of any other Health Care Professionals involved in Resident's care eg: hospice, dietician, private GP etc

Name of Care Home Staff registering patient: