Document 2 Nursing/Care Home Patient Registration Form

Date: Completed by:

Please complete all sections

Name		**DOB**	
Admitted from:			
NOK/ family contact (Please circle one of above)	Name: Relationship: Address: Tel no: mobile:		
Welfare guardian/ Power of Attorney (Please circle one of above)	Name: Address: Tel no: mobile:		
AWI in place? Yes / No		**For Resuscitation?** Yes / No / Needs assessed **DNACPR order in place?** Yes / No	
Consent for sharing information with Out of Hours doctor? Yes / No			
Mobility	Independent Walking aids Needs assistance Bed and chair bound Bedbound (Please circle one only)		
Continence	Continent Urinary incontinence-wears pads/catheter in situ Faecal incontinence (Please circle one only)		
Cognition	No impairment Some confusion 1-2 words only No meaningful interaction (Please circle one only)		
Communication	Speaks clearly Speech difficult to understand Unable to communicate verbally (Please circle one only)		
BP	**Allergies**		
Smoking status	Never smoked Ex-Smoker Current Smoker cigarettes /day (Please circle one only)		
Measurements	Weight	Height	BMI
Flu vaccination given this season? Yes /No			
Falls	Previous Falls? Yes / No	Falls Risk Factors Shared with GP? Yes / No	
Future care wishes	Anticipatory care planning questions given to patient? Yes/No Anticipatory care planning questions given to NOK/POA (please circle one)? Yes/No		
Any other concerns?			