34 Hibiscus Drive, Petit Valley, Diego Martin (868)-682-0224 carettadvent@gmail.com

APPLICATION FOR ADMISSION

PLEASE COMPLETE THE FORM IN BLOCK LETTERS

Name of Applicant:____

LAST FIRST MIDDLE

Is placement considered Short Term _________or Long term________ (check one)?

Room Arrangement: ☐ Shared ☐ Private

Home Address: _______________________________________Telephone No.: ______________________

Date of Birth: ________/ _______/______ Age: ______________ Sex: _________ Citizenship: ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Religion/Church Affiliation: ____

Designated Representative(s):

Name:____

LAST FIRST MIDDLE

Relationship to Applicant: ____

Home Address: ____

Telephone No.: ____

List of Children:

- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________

Present location of the Applicant (if other than home address): ________________________________

Former Residence in a Nursing Home or Adult Care Facility? ☐ **YES** ☐ **NO**

If yes, where? ____

Please state why the applicant is no longer at this facility: ____

Emergency Care:

Emergency Contact: ______________________________ Telephone No.:____

Preferred Hospital in Case of Emergency: ____

List of Visitors (Family or Otherwise):

Name	Relationship

Applicant Care:

Physician: ______________________________ Telephone No.: ______________________

Blood Type: _________________________________

Any recent falls/slips ☐ **YES** ☐ **NO** (if yes, please explain): ______________________________

Any recent surgery (please give details): ____

____

Allergies	☐ YES ☐ NO If yes, please state_______________________________________.

Consent to discuss medical information with next of kin or any other person(s): ☐ **YES** ☐ **NO**

Illnesses	Medications	Dosage	Strength

How many days of medication does the applicant have? _______________________________

I, ____________________________ , confirm that the information provided above is true and correct.

BLOCK LETTERS

Signature: ________________________________ Date: _________/ _______/_____

TO BE COMPLETED BY THE REGISTERING STAFF

Applicant Assessment Needs

Does the Applicant have wondering ☐ **YES** ☐ **NO** or aggressive behaviour ☐ **YES** ☐ **NO**?

Notes:____

Weight: ____________________________

Height: ____________________________

Blood Pressure: _____________________

Glucose Level: ______________________

Pulse: _____________________________

Oxygen Stats: _______________________

Respiratory Rate: ____________________

Any Other Issues:

Mobility	☐ Independent ☐ Walking Aids ☐ Needs Assistance ☐ Bed &Chair Bound
Continence	☐ Continent ☐ Urinary Incontinence – wears pads/catheter in-situ ☐ Faecal Incontinent
Cognition	☐ No Impairment ☐ Some Confusion ☐ 1-2 words only ☐ No meaningful Interaction
Communication	☐ Speaks Clearly ☐ Speech Difficult to Understand ☐ Unable to Communicate Verbally
Hearing Impairment	☐ No Impairment ☐ Hearing Difficulties ☐ Deaf
Sight Impairment	☐ No Impairment ☐ Mid Sight Impairment ☐ Significant Sight Impairment ☐ Blind
Smoking Status	☐ Non-Smoker ☐ Ex-Smoker ☐ Current Smoker______cigarettes per day
Alcohol Status	☐ Non-Drinker ☐ Drinks Alcohol ________________ *(How much?)*

Staff Signature: ____ **Date: _________/ _______/_____**