Brookfield

*Caring when it's needed most.*

# PRE-ADMISSION APPLICATION

*Confidential Document as detailed under the Data Protection Act.*

***To be completed by applicant or family member.***

Surname: ______________________ Forename: ______________________

Address: ______________________________________________

______________________ Telephone Number: ______________________

Date of Birth: ______________________ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other

Geriatrician: ______________________ Date of Last Assessment: ______________

General Practitioner: ______________________________________________

Address: ______________________________________________

______________________ Telephone Number: ______________________

Public Health Nurse: ______________________ Telephone Number: ______________________

Admission from: ☐ Home ☐ Acute Hospital ☐ Community Hospital ☐ Nursing Home

Reason for Admission: ☐ Convalescence ☐ Respite ☐ Long Term Care

Private Health Insurance Details: ______________________________________________

Medical Card Number: ______________________________________________

## NEXT OF KIN DETAILS:

Name: ______________________________________________

Address: ______________________________________________

______________________ Telephone Number: ______________________

Occupation: ______________________ Relationship to Applicant: ______________________

Name: ______________________________________________

Address: ______________________________________________

______________________ Telephone Number: ______________________

Occupation: ______________________ Relationship to applicant: ______________________

## NURSING ASSESSMENT:

*To be completed by Public Health Nurse where possible.*

| FUNCTION | UNABLE | NEEDS HELP | INDEPENDENT |
|---|---|---|---|
| Mobility | | | |
| Transfer from Bed to Chair | | | |
| Steps | | | |
| Toilet Use | | | |
| Bathing | | | |
| Grooming | | | |
| Dressing | | | |
| Feeding | | | |
| | **INCONTINENT** | **OCCASIONAL ACCIDENT** | **CONTINENT** |
| Bladder | | | |
| Bowels | | | |

Medical Appliances Needed: ____________________

____________________

____________________

Special Dietary Requirements: ____________________

____________________

____________________

Wound Care Requirements: ____________________

____________________

____________________

Height: ____________________ Weight: ____________________

Hobbies / Interests: ____________________

____________________

____________________

Signed by: ____________________ Date: __________

## MEDICAL DETAILS:

***To be completed by General Practitioner.***

Name: ______________________________ Age: __________

Address: ______________________________

______________________________ Gender: __________

Date last seen by G.P. service: ______________________________

Reason for Referral: ______________________________

______________________________

______________________________

______________________________

______________________________

Medical Diagnosis: ______________________________

______________________________

______________________________

______________________________

______________________________

Current Medications. ______________________________

______________________________

______________________________

______________________________

______________________________

Allergic to: ______________________________

Past Medical History. ______________________________

______________________________

______________________________

______________________________

______________________________

**VACCINATION STATUS (PLEASE TICK WHERE APPROPRIATE AND WRITE IN DATE GIVEN)**

☐ FLU VACCINE DATE GIVEN: ____________________

☐ PNEUMOCOCCAL VACCINE DATE GIVEN: ____________________

☐ ANTITETANUS DATE GIVEN: ____________________

**PLEASE SUPPLY COPY OF MOST RECENT BLOOD RESULTS F.B.C. U&E'S ETC.**

Mental Health Status: ______________________________

______________________________

______________________________

______________________________

______________________________

History of Verbal/Physical Aggression: ☐ Yes ☐ No

Details: ______________________________

______________________________

______________________________

______________________________

______________________________

Previous Referral to Psychiatric Services: ☐ Yes ☐ No

Details: ______________________________

______________________________

______________________________

______________________________

______________________________

Alcohol Consumption per week: ______________ Cigarette Consumption per day: ______________

Weight: ☐ Above recommended body weight ☐ Normal body weight ☐ Below recommended body weight

Signed by: ______________________________ Date: ______________

## SOLICITORS DETAILS:

Name: ____________________

Address: ____________________

____________________ Telephone Number: ____________________

## NOMINATED FINANCIAL REPRESENTATIVE:

Name: ____________________

Address: ____________________

Telephone Number: ____________________ Email Address: ____________________

Does the above named hold:

Power of Attorney Status? ☐ Yes ☐ No Enduring Power of Attorney Status? ☐ Yes ☐ No

## WARD OF COURT:

Is the applicant a ward of court? ☐ Yes ☐ No

If not is it intended to make an application for ward of court status? ☐ Yes ☐ No

## FAIR DEAL FUNDING STATUS:

Has an application been submitted for Fair Deal Funds? ☐ Yes ☐ No

If yes, what date was application submitted? ____________________

Is the applicant intending to apply for the State loan? ☐ Yes ☐ No

Fair Deal Client Reference No. if available: ____________________