West Kent Federation

NHS

NEW PATIENT FORM FOR RESIDENTS OF CARE HOMES

Resident's Details

Name of Care Home: HAWKHURST HOUSE

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 ☐

Please provide names

Does Resident Have a Power of Attorney Yes ☐ No ☐

Please provide a copy of the power of attorney

Resident's Wishes

Consent to share Enhanced Summary Care Record Yes ☐ No ☐

Does Resident Have Living Will? Yes ☐ No ☐ or Advanced Care Plan (TEP)? 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:

GP Adminstration use only: GP Summary Received ☐ PMR template complete ☐ Pharmacist informed of new resident ☐
Lives in residential home code (13FK) added ☐ and Care Home Enhanced Services Administration (9Kw) added ☐

New Resident Frailty Assessment done by Community Health Care Professional

Ongoing problems (eg diabetes, recurrent infections, falls, challenging behaviour, palliative)

Management plan (eg insulin regime, rescue pack for infections, delirium treatment, escalation plan)

Care home LES and DES codes

394923006	Lives in a residential home
160734000	Lives in a nursing home
192931000006108	New Patient Consultation
134427001	Frail Elderly assessment
1187920000000000	Review of Personalised Care and Support Plan
1239510000000100	Structured medication review
183452005	Emergency Hospital Admission
25711000000101	Initial Post Discharge Review
880331000000106	Management plan for shared care
1929310000006108	Unplanned visits to care home