Pre-Admission Resident Screening Questionnaire

Please complete this form as accurately as possible - this will allow us to calculate your potential care costs.

Please note that the information disclosed here is treated in accordance with the GDPR legislation on confidential information. When we no longer require this information it will be securely destroyed. Should your enquiry progress to an offer of placement, a detailed assessment of the resident will be completed by a member of our staff.

Resident Details

Full Name *

First Name Last Name

Date of Birth *

Day Month Year

Gender *

Male

Female

NHS Number (If Known)

Can be found on any prescriptions/prescription medications.

Religion/Spiritual Belief *

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Current Address *

Street Address

City

County

Post Code

Allergies

Current GP Surgery *

Is there a Power of Attorney in place?

Yes, for Health & Welfare

Yes, for Property & Affairs

Yes, for both

Neither

Have you been advised by a healthcare professional or a social worker to seek a nursing home placement? *

Yes

No

How will the care fees be paid? *

CHC/Fast-Track (end-of-life only)

Local Authority (Council)

Self-Funding

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Next of Kin Details

Name *

First Name Last Name

Relationship to Resident *

Phone Number *

Please enter a valid phone number.

Email

example@example.com

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Resident's Care Needs

Is there a history of falls? *

Yes

No

Is there a history of challenging behaviours? *

Yes

No

How would you describe their mobility? *

Able to walk independently/minimal assistance

Requires some assistance (ie, crutches, zimmer frame)

Immobile/requires full assistance (ie, hoisting & a wheelchair)

What level of risk does the person represent to themselves? *

Low risk - does not attempt to stand/walk without supervision

Medium risk - can infrequently attempt to stand/walk unsupervised, needs moderate or intermittent supervision

High risk - cannot be left alone, very often attempts to move or do things beyond range of ability, needs constant supervision

Is there a diagnosis of dementia in place? *

Yes

In progress/currently being reviewed

No, but strongly suspected

No

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Are they continent/able to control their elimination? *

Yes, fully

Somewhat

No

How would you describe their communication? *

Able to communicate needs clearly, minimal confusion

Able to communicate some needs, mild confusion

Very confused, struggles to communicate needs

Unable to communicate

How independent are they in terms of personal care (ie, eating, dressing, washing)? *

Very independent, needs little assistance & supervision

Somewhat independent, needs some assistance & supervision

Able to cooperate with personal care, but needs a lot of assistance & supervision

Unable to contribute, needs full assistance

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Are you able to tell us a bit about their medical history?

Please list only diagnosed conditions above.

Are they currently taking any medications?

Please list the name and dose of the medications.

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