Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Dublin South, Kildare & West Wicklow
Community Healthcare

APPLICATION FORM FOR PLANNED RESPITE CARE IN RESIDENTIAL SETTING

(All Assessments must be done by a PHN, Doctor, Social Worker or other medical personnel)

HAS RESPITE CARE PREVIOUSLY BEEN ATTENDED: ☐YES ☐ NO

IF YES, STATE FACILITY AND YEAR ATTENDED: ______________________________

CONSENT TO MDT REFERRALS: ☐YES ☐ NO

SECTION 1: PERSONAL DETAILS

NAME: ______________________________ **D.O.B:** ___/___/____ **RELIGION:** ____________

ADDRESS:

____

____ **PHONE NUMBER:** ____________

GMS NUMBER: ______________ **EXPIRY DATE:** __________ **PPS NUMBER:** ____________

NAME AND ADDRESS OF CONTACT PERSON(S)	
NAME:	NAME:
RELATIONSHIP TO APPLICANT:	RELATIONSHIP TO APPLICANT:
ADDRESS:	ADDRESS:
PHONE NUMBER:	PHONE NUMBER:
MOBILE NUMBER:	MOBILE NUMBER:

DATES OF PROPOSED ADMISSION: _____/_____/______ **TO** _____/______/______

Every effort will be made to facilitate your request, however all placements are dependent on bed availability at the time of application.
HAS CLIENT CONSENTED TO RESPITE ADMISSION: Yes ☐ No ☐

Client Name: ______________ D.O.B: ____________________

ARE BOOKING DATES FLEXIBLE: **Yes ☐ No ☐**

REASON FOR THIS ADMISSION:

____

____

____

CURRENT LIVING ARRANGEMENTS: LIVES ALONE ☐ WITH SPOUSE/PARTNER ☐ OTHER ☐

HCA	**Yes** ☐	**No** ☐
IS HOME HELP PROVIDED	**Yes** ☐	**No** ☐
HOME CARE PACKAGE	**Yes** ☐	**No** ☐
MEALS ON WHEELS	**Yes** ☐	**No** ☐
DAY CENTRE	**Yes** ☐	**No** ☐

OTHER: ____

SERVICES APPLIED FOR: ____

SOCIAL CIRCUMSTANCES:

____

____

____

NURSING HOME SUPPORT SCHEME (FAIR DEAL) APPLICATION APPLIED FOR: **Yes ☐ No ☐**

WHAT IS THE CURRENT STATUS OF THIS APPLICATION: ____

____

____

SECTION 2: CARE NEEDS ASSESSMENT

1) COMMUNICATION NEEDS: Has the client any difficulty with:

Hearing: **YES** ☐ **NO** ☐ Vision: **YES** ☐ **NO** ☐

Expressing Needs or Comprehending others: **YES** ☐ **NO** ☐

Additional Information: ____

____

____

2) **HYGIENE NEEDS:**

ASSESSED AS: INDEPENDENT ☐ PROMPTING & DIRECTION NEEDED ☐

ASSISTANCE X 1 ☐ ASSISTANCE X 2 ☐ USE OF AIDS ☐

BARTHEL INDEX: __________

3) **DRESSING:**

Manages unaided **YES** ☐ **NO** ☐

Uses an aid/equipment **YES** ☐ **NO** ☐ please specify: ______________________

Requires help x1 ☐ Totally reliant x 1 ☐ Needs help x 2 ☐

4) **MOBILITY:**

- ☐ Walks independently without aids or help ______________________
- ☐ **Walks independently with aids: Stick** ☐ **Zimmer Frame** ☐ **Rolator** ☐
- ☐ Walks with assistance of one person ______________________
- ☐ Walks with assistance of two people ______________________
- ☐ Unable to walk ______________________
- ☐ Uses Wheelchair ______________________

Frase or Alternative Assessment Tool: ______________________

Has your client ever fallen? YES ☐ **NO** ☐
If Yes - Did this occur within the last: 6 Months+ ☐ 3 Months ☐ 6 Weeks ☐

CAUSE OF FALL(S):

Slip/Trip	
Loss of Balance	
Collapse	
Legs gave way	
Dizziness	
Others	

ANY INJURY SUSTAINED? YES ☐ **NO** ☐ If yes describe nature of injury ______________________

____

5) **COGNITIVE FUNCTION AND BEHAVIOURAL PATTERNS:**

CLIENT'S COGNITIVE FUNCTION CAN BE DESCRIBED AS:

Client Name: ______________ D.O.B: ____________________

INTACT ☐ MILDLY IMPAIRED ☐ MODERATELY IMPAIRED ☐ SEVERELY IMPAIRED ☐

MMSE SCORE: ______________

OTHER COGNITIVE TEST SCORE AVAILABLE: ____________________

General Psychological Features

Please indicate if any of the following features are present:

- ☐ Physical aggression
- ☐ Verbal aggression
- ☐ Impulsivity
- ☐ Sleeping difficulties
- ☐ Loss of insight/ denial of deficits
- ☐ Depression
- ☐ Agitation/ Restlessness
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Fatigue/Lethargy
- ☐ Anxiety
- ☐ General slowness
- ☐ Sexual disinhibition
- ☐ Mood Swings
- ☐ Loss of previously acquired knowledge
- ☐ Confusion/ disorientation
- ☐ Exploratory walking with no intention to exit
- ☐ Exploratory with intent to exit
- ☐ If going out of the unit / home (unsafe exiting)

Behavioural & Psychological Symptoms of Dementia (BPSD) /Responsive Behaviour that may impact on ability to integrate with other residents:

____

____

____

Please give details of potential triggers or patterns of behaviour:

____

____

____

6) **<u>ELIMINATION PATTERN</u>**: Does your client have:

Urinary Incontinence: ☐ Faecal Incontinence: ☐ Both: ☐ Stoma: ☐

Urinary Catheter: ☐ Supra Pubic Catheter: ☐

Incontinence Wear: Day ☐ Night ☐

Type of Day Wear: ____________________

Type of Night Wear: ____________________

RECENT WEIGHT LOSS: YES ☐ NO ☐

THICKENED FLUIDS ☐ SWALLOWING DIFFICULTY ☐ NEEDS MODIFIED DIET ☐

NG FEEDING / GASTROSTOMY ☐

FEEDING REGIME COMMENTS:

____

____

ANY FOOD ALLERGIES: YES ☐ NO ☐ IF YES PLEASE STATE: ______________

SPECIAL DIETARY REQUIREMENTS: ______________________________

SLT REPORT AVAILABLE: YES ☐ NO ☐ IF YES PLEASE ATTACH SLT REPORT IF AVAILABLE

8) SKIN CONDITION:

BRADEN or WATER LOW SCORE: ______________________

SKIN INTEGRITY/ SKIN CONDITION:

INTACT ☐ DRY ☐ BROKEN ☐ RASH ☐ BRUISING ☐ WOUND ☐ PRESSURE ULCER ☐

Please comment if any of the above present and include location:

____

Treatment and management of same:

____

____

____

9) INFECTION CONTROL:

____

____

10) EQUIPMENT:

Microorganism	Previous History Yes/No	Date of screen, if available	Result if available
MRSA			
C.DIFF			
ESBL			
VRE			
CPE/CRE			

DOES CLIENT REQUIRE SPECIAL EQUIPMENT:

- ❑ Pressure Relieving Mattress..
- ❑ Pressure Relieving Cushion..
- ❑ Transfer Aid...
- ❑ Hoist ....
- ❑ Powered Chair..
- ❑ Wheelchair ....
- ❑ Specialised seating ....
- ❑ Other ....

11) <u>RESPIRATORY STATUS</u>:

Does your client use any respiratory equipment?

E.G OXYGEN, SUCTION, NEBULISER, BIPAP/C- PAP MACHINE, INHALERS

YES ☐ **NO** ☐

IF YES, PLEASE STATE:

____

____

____

12) <u>SLEEP/REST</u>: STATE NORMAL SLEEP PATTERN

____

____

____

Client Name: ______________ D.O.B: ____________________

SECTION 5: HEALTH PROFESSIONAL TO COMPLETING:

NAME: ______________________ **JOB TITLE:** ______________________

WORK ADDRESS: ____

OFFICE NUMBER ______________________ **MOBILE NUMBER** ______________________

SIGNED ______________________ **DATE** ____/____/____

FAX NO: ______________________ **EMAIL:** ______________________

DISCIPLINE	NAME	HEALTH CENTRE	PHONE NUMBER	FAX NUMBER
PHN /CRGN				
COMMUNITY CARE ASSISTANCE				
SOCIAL WORKER				
HOME HELP				
PHYSIOTHERAPIST				
OCCUPATIONAL THERAPIST				
GERIATRICIAN				
PSYCHIATRIST OF LATER LIFE				
PHARMACIST				
DIETICIAN				
S.L.T				
HOSPICE TEAM				
HOME CARE PACKAGE AGENCY				
HOME HELP ORGANISER				
MEAL ON WHEELS				
CONSULTANT				
GENERAL PRACTITIONER				
DAY CARE CENTRES M T W TH F				

Client Name: ______________ D.O.B: ______________

SECTION 4: FOR CLIENT OR CLIENTS CONTACT PERSON TO READ AND SIGN:

<u>I understand that I must submit a current, accurate copy of the GMS prescription form on admission to the respite unit assigned</u>. *On admission I will arrive with enough supplies of medication in their original packaging,* ***<u>and if relevant</u>***, *will bring in my warfarin book, supplies of incontinence wear, respiratory equipments and any mobility aids utilised. I agree to the admission and discharge dates offered and Terms and Conditions of admission. I understand that my transport and escorts must be arranged for any appointments while on admission and discharge.*

SIGNED ______________________________ **(CLIENT) DATE:** ____________________

PHONE NUMBER: ____________________

IF SIGNING ON BEHALF OF CLIENT PLEASE COMPLETE THE FOLLOWING:

SIGNED: ______________________________ **DATE:** ____________________

RELATIONSHIP TO CLIENT: ______________________________

PHONE NUMBER: ______________________________

PLEASE RETURN COMPLETED FORM TO:

____

____

____

____

G.P. TO COMPLETE

CLIENT NAME: ______________________________ **CLIENT DOB:** ____/____/______

Client Name: ______________ D.O.B: ____________________

DIAGNOSIS/MEDICAL HISTORY: ____________________

____

____

Known Allergies: ____________________

History of MRSA: **Yes** ☐ **No** ☐ Date: ________ **History of C. Diff:** **Yes** ☐ **No** ☐ Date: ________

VRE/CRE: ____________________ **MMSE: (cognitive screening):** ____________________

CONSULTANT INVOLVEMENT: [Please complete table below]

Please attach recent letters or reports received

Name of Consultant	Clinic Attended	Date Of Last Visit

LIST MEDICATIONS OR ATTACH PRINTED LIST WITH GP STAMP

NAME OF MEDICATION	DOSE	FREQUENCY

Please note an up to date prescription is required on day of admission

Is Client on Warfarin? **Yes** ☐ **No** ☐ **Last INR range**__________ **Date**________ **Clinic**______________

Is Client on Insulin? **Yes** ☐ **No** ☐ **Sliding scale** **Yes** ☐ **No** ☐

Has Client received seasonal Influenza vaccine? **Yes** ☐ **No** ☐ Date______________

Has Client received Pneumococcal Vaccine? **Yes** ☐ **No** ☐ Date______________

Covid vaccination 1st Dose ☐ – Date.
2nd Dose ☐ – Date.

I am satisfied that the medications listed accurately accounts for this patient's current medication regime

GP SIGN: ____________________ **PRINT NAME:** ____________________

GP PHONE: ____________________ **GP FAX:** ____________________

ADDRESS: ____________________

Date: ____/_____/______

RETURN TO: ____________________

Client Name: ______________ D.O.B:______________