Feidhmeannas Seirbhíse Sláinte
Health Service Executive

Health Service Executive
Integrated Service Area
Dublin Mid-Leinster

APPLICATION FORM FOR PLANNED RESPITE CARE

(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 REFERALS: ☐ **YES** ☐ **NO**

SECTION 1: PERSONAL DETAILS

NAME: _____D.O.B _____/_____/_____RELIGION _____

ADDRESS: _____

_____PHONE NUMBER_____

GMS NUMBER_____EXPIRY DATE: _____ PPS NUMBER_____

NAME AND ADDRESS OF NEXT OF KIN/ CONTACT PERSON	
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** ☐
ARE BOOKING DATES FLEXIBLE **Yes** ☐☐ **No** ☐

REASON FOR THIS ADMISSION:

_____

_____

_____

CLIENT NAME: _____*ADDRESS*: _____

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** ☐

OTHER 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 x 1 ☐ 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 PLUS _ 3 MONTHS _ 6 WEEKS _

Cause of Fall:

Slip/Trip	
Loss of Balance	
Collapse	
Legs Gave Way	
Dizziness	
Other(s)	

ANY INJURY SUSTAINED? YES □ □ NO □ If Yes Describe Nature of Injury:
_____

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5) COGNITIVE FUNCTION AND BEHAVIOURIAL PATTERNS

CLIENT'S COGNITIVE FUNCTION IS**:**

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
□ Exploratory Walking with No Intention to exit
□ If going out of unit/home (unsafe exiting)
□ Poor Concentration
□ Fatigue/ Lethargy
□ Anxiety
□ General Slowness
□ Sexual Disinhibition
□ Mood Swings
□ Loss of Previously Acquired Knowledge
□ Confusion/ Disorientation
□ Exploratory Walking with Intent to Exit

CLIENT NAME: _____*ADDRESS:* _____

5B) Specify any Behavioural & Psychological Symptoms of Dementia (BPSD) / Responsive Behaviours that may impact on ability to integrate with other residents:

_____

_____

Please give details of potential triggers or patterns of behaviour:

_____

_____

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6) ELIMINATION PATTERN: DOES YOUR CLIENT SUFFER WITH:

URINARY INCONTINENCE □ FAECAL INCONTINENCE □ Both: □ Stoma □ Urinary Catheter □

Supra Pubic Catheter □

Incontinence Wear: Day □ Type: _____

Night □ Type: _____

OTHERS: _____

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7) NUTRITIONAL STATUS:

CURRENT WEIGHT: _____ RECENT WEIGHT LOSS **YES** □ **NO** □

Thickened Fluids □ Swallowing Difficulty □ Needs Modified Diet □ NG/Gastrostomy □

Feeding Regime Comments:

_____

_____

Any Food Allergies: Yes □ **No** □ If YES, Please State: _____

SPECIAL DIETARY REQUIREMENTS: _____

SALT Report Available Yes □ **No** □ **IF YES PLEASE ATTACH IF AVAILABLE**

_____

8) SKIN CONDITION:

WATERLOW / BRADEN 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:

_____

_____

CLIENT NAME: _____*ADDRESS:* _____

9) Infection Control:

_____

_____

Microrganism	Previous History Yes/No	Date of screen, if available	Result if available
MRSA			
C Diff			
ESBL			
VRE			
CPE/CRE			

10) EQUIPMENT

DOES CLIENT REQUIRE SPECIAL EQUIPMENT

- ❑ Electric Bed……..
- ❑ Pressure Relieving Mattress…….
- ❑ Pressure Relieving Cushion…….
- ❑ Transfer Aid ……
- ❑ Hoist ……
- ❑ Powered Chair
- ❑ Wheelchair
- ❑ Specialised Seating

Other (please specify)……..

_____

11) RESPIRATORY STATUS: DOES THE CLIENT UTILISE ANY RESPIRATORY EQUIPMENT E.G. OXYGEN, SUCTION, NEBULISATION, BIPAP/C-PAP MACHINE, INHALERS ETC. **YES** ☐ **NO** ☐

If Yes Please Describe: _____

_____

12) SLEEP/REST: STATE NORMAL SLEEP PATTERN

_____

_____

_____

CLIENT NAME: _____ADDRESS: _____

SECTION 3: HEALTH PROFESSIONAL APPLYING TO COMPLETE:

NAME: _____**JOB TITLE**: _____

WORK ADDRESS: _____

OFFICE NUMBER_____**MOBILE NUMBER**_____

SIGNED_____**DATE**_____/_____/_____

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

CLIENT NAME: _____ADDRESS: _____

SECTION 4: FOR CLIENT OR CLIENTS NEXT OF KIN TO READ AND SIGN:

I understand that I must submit a current, accurate copy of the GMS prescription form on admission to the respite unit assigned*. On admission I will arrive with enough supplies of medication in their original packaging,* ***and if relevant****, 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 FORWARD THE COMPLETED RESPITE APPLICATION FORM TO:

Email: cho7.shortstaybeds@hse.ie
Address: SSR Office, Oak House, Millennium Park, Naas, Co. Kildare.
Phone Numbers: 086 4108521 / 087 2870824 / 086 6041040

G.P. TO COMPLETE

CLIENT NAME: _____CLIENT DOB: _____/____/_____
CLIENT ADDRESS: _____

All respite clients are required to be under the care of consultant Geriatrician or have psychiatry of old age involvement. Please attach recent letters from these disciplines.

DIAGNOSIS/MEDICAL HISTORY: _____

_____

_____

_____

Date of last Flu Vaccine: _____MMSE SCORE _____

CONSULTANT INVOLVEMENT: [Please complete table below]:

	Name of Consultant	Clinic Attended	Date Of Last Visit

MEDICATION LIST:

NAME OF MEDICATION	DOSE	FREQUENCY

Is patient on warfarin Yes □ NO □ INR range_____ Clinic_____

Does client self-medicate? Yes □ No □ Allergies □ Yes □ No □

Has client received seasonal Influenza vaccine Yes □ No □ Date_____

Has client received Pneumococcal Vaccine Yes □ No □ Date_____

Covid Vaccinations 1 & 2 Received: Yes □ No □ Date_____

Covid Boosters Received: Yes □ No □ Date_____

All clients must receive seasonal Influenza vaccine prior to admission as per HPSC guidelines, unless contra- indicated by their Doctor.

I am satisfied that the medications listed accurately accounts for this patient's current medication regime. NO DS

GP SIGN: _____PRINT NAME: _____DATE_____

GP PHONE_____GP FAX_____ ADDRESS_____