



MANSFIELD CARE

## Pre-Admission Form

[Care Home Name] | [Address] | [Phone] | [Email]

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### Section 1: Resident Details

|                               | Details |
|-------------------------------|---------|
| <b>Name of Resident</b>       |         |
| <b>Likes to be known as</b>   |         |
| <b>Date of Birth</b>          |         |
| <b>National Insurance No.</b> |         |
| <b>Religion</b>               |         |
| <b>Place of Assessment</b>    |         |
| <b>Date of Assessment</b>     |         |
| <b>Who was present</b>        |         |

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### Section 2: Contact Information

|   | Details |
|---|---------|
| <b>GP Name</b>                          |         |
| <b>GP Surgery Address &amp; Contact</b> |         |
| <b>Social Worker Name &amp; Tel</b>     |         |
| <b>Person Conducting Assessment</b>     |         |
| <b>Designation</b>                      |         |
| <b>Next of Kin Name &amp; Address</b>   |         |
| <b>Next of Kin Contact Number</b>       |         |
| <b>Mobile Telephone Number</b>          |         |

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### Section 3: Social & Legal Information



|   | <b>Details</b> |
|---|----------------|
| <b>AWI, DNACPR, POA/NOK Information</b> |                |
| <b>Document applicable (Yes/No)</b>     |                |
| <b>Copy/Original obtained</b>           |                |
| <b>Date for renewal</b>                 |                |

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#### Section 4: Financial Information

|  | <b>Details</b> |
|--|----------------|
| <b>Access to own funds?</b>                      |                |
| <b>How do you access this money?</b>             |                |
| <b>Support needed to access/maintain funds?</b>  |                |
| <b>Arrangements for personal items purchases</b> |                |
| <b>(Cashless home arrangements discussed)</b>    |                |

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#### Section 5: Medical & Health Information

|  | <b>Details</b> |
|--|----------------|
| <b>Past Medical History</b>  |                |
| <b>Current Medical Condition (if diabetic – cover stability, input and management)</b> |                |



| Details   |
|---|
| <b>Immediate health needs:</b> (Any MDT input, SALT, falls, Diabetes)   |
| <b>Choking risk –</b> (detail risk of choking, previous choking episodes, any historical or current medical intervention, support required, SALT input, any swallowing difficulty eg pocketing food, coughing after eating – give details of support and supervision required). |
| <b>Specialist/Requested Equipment Needed</b><br><br>(Sensors, bedrails, raised toilet seat, handrails etc)  |
| <b>Cognitive Ability/Behaviour</b> (give details of risk, supervision required, de-escalation techniques, prn protocols)  |
| <b>Communication</b> (hearing, sight, speech) Glasses? Hearing aids?  |
| <b>Mobility</b> (moving safely, equipment, support, history of falls, any patterns in falls or instability, restlessness or risk)   |



|  | <b>Details</b>  |
|--|---|
| <b>Eating &amp; Drinking</b>   | (Any specialised diets, modified diets?<br>SALT input)  |
| <b>Personal Hygiene Needs</b> (resistant or<br>reluctance, patterns and routines,<br>preferences, risks) |   |
| <b>Expressing Sexuality</b> (clothing<br>preferences, make up, perfume,<br>shaving, hair preferences)    |   |
| <b>Elimination</b>   | (Continent?, Are continence aids<br>required? Size?)  |
| <b>Sleeping &amp; Resting</b>  | (Full nights sleep? Restless overnight?<br>Sleeping patterns – rise and settle times,<br>routines, how many pillows? etc) |
| <b>Interests/Hobbies</b>   |   |
| <b>Breathing</b>   |   |
| <b>Pain</b>  |   |



|   | <b>Details</b>   |
|---|--|
| <b>List of Medication</b>                               | Any specialised medication routines?<br>Diabetes? Parkinsons meds etc?         |
| <b>Any Known Allergies</b>                              |  |
| <b>Pressure Areas</b>                                   | (Prone to skin breakdown, wounds etc? Current or past breakdown/vulnerability) |
| <b>Death &amp; Dying Wishes</b>                         | Funeral plans insitu?, end of life wishes?                                     |
| <b>Likes/Dislikes</b>                                   |  |
| <b>Care Plans Identified</b>                            |  |
| <b>Can the home meet the resident's needs? (Yes/No)</b> |  |
| <b>Other Notes</b>                                      |  |

|                                       | <b>Details</b> |
|---------------------------------------|----------------|
| <b>Signed (Team member assessing)</b> |                |
| <b>Position</b>                       |                |



MANSFIELD CARE

|                                   | <b>Details</b> |
|-----------------------------------|----------------|
| <b>Date</b>                       |                |
| <b>Comment:</b>                   |                |
| <b>Signed (Resident if able)</b>  |                |
| <b>Position</b>                   |                |
| <b>Date</b>                       |                |
| <b>Comment</b>                    |                |
| <b>Signed (POA if applicable)</b> |                |
| <b>Position</b>                   |                |
| <b>Date</b>                       |                |
| <b>Comment</b>                    |                |