

Pre-Admission Form

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

Section 1: Resident Details

	Details
Name of Resident	
Likes to be known as	
Date of Birth	
National Insurance No.	
Religion	
Place of Assessment	
Date of Assessment	
Who was present	

Section 2: Contact Information

	Details
GP Name	
GP Surgery Address & Contact	
Social Worker Name & Tel	
Person Conducting Assessment	
Designation	
Next of Kin Name & Address	
Next of Kin Contact Number	
Mobile Telephone Number	

Section 3: Social & Legal Information

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

Section 4: Financial Information

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

Section 5: Medical & Health Information

	Details
Past Medical History	
Current Medical Condition (if diabetic – cover stability, input and management)	



	Details
Immediate health needs: (Any MDT input, SALT, falls, Diabetes)	
Choking risk – (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).	
Specialist/Requested Equipment Needed (Sensors, bedrails, raised toilet seat, handrails etc)	
Cognitive Ability/Behaviour (give details of risk, supervision required, de-escalation techniques, prn protocols)	
Communication (hearing, sight, speech) Glasses? Hearing aids?	
Mobility (moving safely, equipment, support, history of falls, any patterns in falls or instability, restlessness or risk)	



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



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

	Details
Signed (Team member assessing)	
Position	



	Details
Date	
Comment:	
Signed (Resident if able)	
Position	
Date	
Comment	
Signed (POA if applicable)	
Position	
Date	
Comment	
