**Shelleypark**

neuro care centre

Quality care enhancing lives

Pre-Admission

Application Form

**Shelley Park Neuro Care Centre**
32 Florence Road
Bournemouth
Dorset
BH5 1HQ

**Administration**
Telephone: +44 (0) 1202 396446
Facsimile: +44 (0) 1202 396446
Email: shelleypark@lineone.net

## Pre-Admission Application Form

This form will help us assess patients for care and/or rehabilitation at Shelley Park Neuro Care Centre. Please provide as much information as you can and to assist our Admissions Officer, please print clearly or type for maximum clarity.

The information you provide is confidential. Please fill in all relevant sections with as much detail as possible. This will allow us to assess the application quickly and efficiently.

Please attach any supporting materials including a recent medical summary, current therapy assessments and social worker's report and psychology assessments where applicable.

If required, our Admissions Officer is available to assist you to complete this form.

Please tick the service(s) you require:

- ☐ **Assessment**
- ☐ **Continuing Care**
- ☐ **Respite Care**
- ☐ **Day Care**

Please return this form to the Admissions Officer at

**Shelley Park Neuro Care Centre**
32 Florence Road
Bournemouth
Dorset
BH5 1HQ

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## PERSONAL DETAILS

Name:

Sex:

Date of Birth:

National Insurance No.:

Nationality:

Home Address:

Telephone:

Present address (Hospital etc):

Telephone:

Marital Status:

Next of Kin:

Name:

Relationship:

Address:

Family Support:

Religion:

Occupation:

## MEDICAL DETAILS

Primary Diagnosis:

Date of onset of disorder or injury:

### MEDICAL HISTORY

**Disorder:**

- ☐ Diabetes mellitus
- ☐ Epilepsy
- ☐ Malignancy (specify):
- ☐ Known Hepatitis (specify):
- ☐ MRSA
- ☐ Tuberculosis

- [ ] AIDS
- [ ] Known HIV positive
- [ ] Other infectious disease (specify):
- [ ] Drug/ alcohol abuse

**Other medical conditions:**

**Medication:**

**Relevant Investigations Reports** (e.g. blood tests, radiography, CT/MRI scans, EEG)

## PRESENT CLINICAL STATE

Weight (kgs): Height (cms):

Skin -

**Incontinence of urine:**

- [ ] Yes (Method of control):
- [ ] No

**Bowel Problems**: (e.g. incontinence, constipation or diarrhoea) and present treatment:

**Feeding**

- [ ] Independently
- [ ] Independently if encouraged
- [ ] Feeds with assistance
- [ ] Has to be fed (orally)
- [ ] Nasogastric + oral feeding
- [ ] Nasogastric feeding
- [ ] Gastrostomy feeding + oral feeding
- [ ] Gastrostomy feeding

If gastrostomy or nasogastric please state type of tube:

Date of placement:

**Fluid and Food Intake**

| | Food | Fluids |
|---|---|---|
| No difficulty | ☐ | ☐ |
| Swallows with difficulty | ☐ | ☐ |
| Some choking | ☐ | ☐ |
| Unable to swallow | ☐ | ☐ |

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**Special diets or food preparation:**

**Special nursing needs and equipment:**

**Physical Features:**

**Walking:**

- ☐ Walks independently without aids or help
- ☐ Walks independently with aids
- ☐ Walks with assistance of one person
- ☐ Walks with assistance of two people
- ☐ Unable to walk

**Balance:**

- ☐ Good balance in all positions
- ☐ Unsteady when walking; sitting and standing balance good
- ☐ Unable to maintain posture in chair
- ☐ Unsteady standing but maintains sitting balance

**Wheelchair Use:**

- ☐ Not applicable
- ☐ Manual driven wheelchair - self propelled
- ☐ Manual driven wheelchair - with attendant
- ☐ Power driven wheelchair

Model of wheelchair:

Provided by:

Comments:

**Contractures or Limited Range of Movement** (please describe site and severity):

**Motor Features**

- ☐ Hemiplegia / paresis
- ☐ Paraplegia / paresis
- ☐ Tetraplegia / paresis
- ☐ Other (*please state*)

Increased muscle tone: Muscle group(s):

Decreased muscle tone: Muscle group(s):

Ataxia:

Spasms:

### Sensory Features

☐ Visual Impairment? ☐ Auditory Impairment
☐ Other (*please state*): ....................................................

....................................................

| | Independent | With assistance | Dependent | Comment |
|---|---|---|---|---|
| Dressing: | | | | |
| Grooming: | | | | |
| Toiletting: | | | | |
| Transferring: (*bed to chair*) | | | | |

## COMMUNICATION

### Verbal

☐ None ☐ Limited conversation
☐ Can only explain simple needs ☐ Within normal limits

**Ability to indicate yes / no consistently:** ☐

Describe method: ....................................................

....................................................

### Alternative Communication

☐ Gesture ☐ Uses communication aid (give details)

### Comprehension of Communication

Does the patient appear to understand what is said to him/her?

☐ Not at all ☐ Follows most conversations
☐ Only follows simple instructions ☐ Within normal limits

## PSYCHOLOGICAL FEATURES

LEVEL OF COGNITIVE FUNCTIONING

Which of the following categories does the patient fall into?

☐ No response:
*Unresponsive to any stimuli, unconscious.*

☐ Generalised response:
*Reacts inconsistently and non-purposefully to stimuli.*

☐ Localised response:
*Reacts specifically but not inconsistently to stimuli. May follow simple instructions but inconsistently and delayed.*

☐ Confused - agitated:
*Heightened state of activity. Detached and responds primarily to own internal confusion. Speech often incoherent. Poor attention span.*

☐ Confused - inappropriate:
*Appears alert; responds to simple commands. May respond to external situations with anxiety. Easily distracted. Speech often inappropriate. Memory severely impaired.*

☐ Confused - inappropriate:
*Needs instructions to carry out activities. Responds to stimuli appropriately. Shows carryover for tasks which have been relearned.*

☐ Automatic - appropriate:
*Appears to respond appropriately and well oriented in hospitals or home setting. Has shallow recall, superficial awareness but lacks insight. Judgement impaired. Does not cope with new situations very well.*

☐ Purposeful - appropriate:
*Alert and orientated. Social, emotional and intellectual capacities may be at a decreased level but functions well in society.*

☐ Normal
What is response to?:
Tactile stimuli: ..........
Painful stimuli: ..........
Auditory stimuli: ..........
Visual stimuli: ..........

**General Psychological Features**

Please indicate if any of the following features are present:

☐ Physical aggression
☐ Verbal aggression
☐ Irritability
☐ Impulsivity

☐ Poor concentration
☐ Fatigue/ lethargy
☐ General slowness
☐ Anxiety

- ☐ Manipulation behaviour
- ☐ Sexual disinhibition
- ☐ Agitation/ restlessness
- ☐ Confusion/ disorientation
- ☐ Loss of insight/ denial of deficits
- ☐ Depression
- ☐ Mood swings
- ☐ Loss of previously acquired knowledge
- ☐ Loss of new learning ability

**Social Information:** ........................................

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# FINANCIAL DETAILS

**Financial Support**

Name of Health Authority, NHS Trust, Local Authority, GP, Medical or Insurance Company or individual accepting (or requested to accept) financial responsibility for the applicant.

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**Social Security Benefits and Pensions**

The applicant is in receipt of the following Social Security Benefits:

- ☐ Disability Living Allowance (Mobility)
- ☐ Disability Living Allowance (Care)
- ☐ War pensions for .................................. percentage disability
- ☐ Invalidity Benefit
- ☐ Incapacity Benefit
- ☐ Attendance Allowance
- ☐ Income Support
- ☐ Retirement Pension
- ☐ Other State Benefits (State)
- ☐ Occupational / Personal Pension of £ ...................................... Per month

**Additional Information** (*e.g. benefits or pensions applied for but not yet received*): ........................................

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## CONTACTS

Please complete to enable us to contact relevant people for further information should it be required.

Hospital:

Ward:

Please provide the name, telephone number, and (if different from above), the address of the following professional contacts:

Consultant:

General Practitioner:

Ward Sister / Community Nurse:

Social Worker:

Physiotherapist

Occupational Therapist:

Speech Therapist:

Psychologist:

Dietitian:

Other relevant contact(s):

Signature: Date:

Name (*In block letters*):

## REPORTS

Please enclose the following reports:

- ☐ Recent Medical Summary
- ☐ Therapy Assessment
- ☐ Social Worker's Report
- ☐ Psychology Assessment

**Please check that you have completed all sections before returning this form.**