ASCOT MEDICAL CENTRE

# Registration Form

## All sections of this form must be completed & all requests for Consent are Mandatory

# ASCOT GRANGE CARE HOME

Room Number_____ Floor_____ DEMENTIA ☐
NURSING ☐
RESIDENT ☐

Date_____ Permanent resident ☐ Temporary resident ☐

Date of Birth: _____

Title: _____ Forename: _____ Surname: _____

Signed:_____ Date: _____

---

Blood pressure: _____ SYSTOLIC / _____ DIASTOLIC

Pulse rate: _____ BPM

PLEASE PROVIDE CONFIRMATION OF ANY COMMUNICATION/IMPAIRMENT

☐Impairment to communicate:
☐Hearing impairment
☐Visual impairment
☐Cognitive impairment
☐Difficulty communicating
☐Speech problem

☐Patient wear glasses / contact lenses Yes ☐ No ☐
☐Patient has hearing aids? Yes ☐ No ☐
- Hearing aids: Left ☐ Right ☐ Bilateral ☐

ASCOT MEDICAL CENTRE

# Registration Form

## All sections of this form must be completed & all requests for Consent are Mandatory

**Please tick the one most appropriate to patient**

1 .☐ Normal activity with some effort, some signs of symptoms
2. ☐ Care for self, unable to carry out normal activity or do active work
3. ☐ Occasional assistance but can care for most needs
4 .☐ Requires considerable assistance and frequent medical care
5. ☐ In bed more than 50% off the time
6. ☐ Almost completely bedfast
7. ☐ Totally bedfast and requiring nursing care

**In general, do you have health problems that require you to limit your activities?**

Yes ☐ No ☐

**Falls Risk:** Low risk ☐ At risk ☐ High risk ☐

**Number of falls in the last year?** _____

**Mobility:**

☐Independent walking
☐Walking frame
☐Stick only for Walking
☐Independent wheelchair use
☐Minimal help in wheelchair
☐Immobile/Bedridden

**Stairs:**
Independent on stairs ☐ Assistance on stairs ☐ Unable to climb stairs ☐

**Disability:**
Impaired ability to recognise safety risks ☐ No known disability ☐

**Frailty:** Moderate ☐ Severe ☐

**Able to summon help in an emergency?** Yes ☐ No ☐

ASCOT MEDICAL CENTRE

# Registration Form

## All sections of this form must be completed & all requests for Consent are Mandatory

**Eating:** Dependent ☐ Needs Assistance ☐ Independent ☐

**Swallowing:**

☐No problems swallowing
☐Difficulty swallowing solids
☐Difficulty swallowing liquids
☐Swallowing painful
☐Chokes when swallowing

**Personal care:** Dependent ☐ Needs assistance ☐ Independent ☐

**Dressing:** Dependent ☐ Needs assistance ☐ Independent ☐

**Continence:** **Bladder** Fully Continent ☐ Occasional Accident ☐
Incontinent ☐ Catheter in situ ☐

**Bowel** Fully Continent ☐ Occasional Accident ☐
Incontinent ☐ Stoma in situ ☐

**Skin at risk (specify location):**
Good skin health ☐ Skin at risk of ulcer ☐ Skin ulcer present ☐

**Pressure ulcer assessment**: Required ☐ Not Required ☐

**Authority of Lasting Power of Attorney**

Name: _____

Relationship: _____

**Does the Resident have:**

RESPECT form Yes ☐ No ☐

ASCOT MEDICAL CENTRE

# Registration Form
## All sections of this form must be completed & all requests for Consent are Mandatory

## Seasonal Flu Vaccinations Consent Form (MANDATORY)

Seasonal flu vaccinations are offered each September/October onwards to patients in at risk categories and/or over the age of 65 years old. As a resident at **Ascot Grange Care** Home, you are entitled to your free annual flu vaccination.

I DO wish to have the flu jab administered each year ☐

I do NOT wish to have the flu jab administered each year ☐

By signing this form, I consent to having the annual season flu vaccination administered each year unless I notify the Surgery otherwise (in writing) in the future.

Signed: _____

Print Name: _____ Date: _____

**FOR RESIDENTS WHO ARE UNABLE TO SIGN INDEPENDENTLY:**

I DO wish my relative to have the flu jab administered each year ☐

I do NOT wish my relative to have the flu jab administered each year ☐

By signing this form, I consent to my relative _____ having the annual season flu vaccination administered each year unless I notify the Surgery otherwise (in writing) in the future.

Signed: _____

Print Name: _____ Date: _____

Relationship to Patient: _____