

Registration Form

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

ASCOT GRANGE CARE HOME v5

Room Number _____ Floor _____ DEMENTIA ☐
NURSING ☐
RESIDENT ☐

Date _____ Permanent resident ☐ Temporary resident ☐

Date of Birth: _____

Title: _____ Forename: _____ Surname: _____

Next of Kin & Contact Telephone No: _____

Authority of Lasting Power of Attorney

Name: _____

Relationship: _____

Does the Resident have:

DNACPR form Yes ☐ No ☐

Respect form Yes ☐ No ☐

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

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 ☐

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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% of 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 ☐



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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 ☐

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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: _____