

**Application Form**

**Dr Booth Day Centre**

Full Name & Title:

Address:

Postcode: Tel. No:

Date of Birth: Email

Marital Status: Religion:

Next of Kin: Relationship to Applicant:

Tel. No: Email:

Other Contact: Tel. No:

Referred by:

Doctor/Surgery: Tel. No:

Will your care be funded? Privately Social Services/NHS

Social Worker Name: Tel. No:

Invoice address if different from service user’s:

Preferred Days: Mon Tues Wed Thur Fri Sat

Do you require transport? Yes / No\*

**Covid -19 vaccinations Date: 1ST\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ 2ND \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_**

**Please provide proof of vaccinations.**

**Lateral flow testing will be carried out prior to attendance.**

**\* If using the Day Centre transport and a positive result is identified all individuals on the bus will need to return home and contact 119 for guidance, Family contacts must be available.**

**Social distance and hand hygiene compliance in line with Public Health Guidelines.**

Please state your past medical history and any existing medical conditions:

Please list all current medication prescribed by your GP and/or homely remedies from the chemist **(please complete form attached)**

Please list any allergies to medication or substances:

**Please answer the following questions as best you can:**

Eating and Drinking: Do you need help cutting up your food?

 Do you have any special dietary requirements? (e.g. Diabetic,

 Vegetarian, Coeliac)

 Do you eat a normal, soft or liquidised diet?

 Do you need food supplements?

 Do you have any food allergies?

Passing Urine: Do you have full control?

 Do you need a pad to promote your continence?

 Do you require a urethral catheter tube?

 Do you need reminding to use the toilet?

Do your bowels: Work Normally?

 Let you down from time to time?

 Need assistance from a nurse or carer?

 Require a pad due to leakages?

Bathing Do you require a bath?

 Do you need supervision? If yes, how many carers assist?

Additional Services Bathing Facilities/ hairdresser available by appointment?  **\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_**

Dressing & Undressing**:** Can you manage independently?

 Do you need help? If yes, how many carers assist?

Mobility: Can you get up and walk on your own?

 Do you need some help?

 Do you use any of the following mobility aids?

 Zimmer Frame

 Sticks

 Stand Aids

 Hoist

 Wheelchair

 Wheelchair – outside use only

Do you have any special cushions on your chair to sit on?

Can you see: Well / with difficulty / not at all?

 Do you wear spectacles?

Can you hear: Normally / with a hearing aid?

Communication: Do you normally understand what people say?

 Can you understand people but with difficulty?

 Can you not understand people at all?

 Can you express yourself vocally?

Do you become confused: Occasionally / a lot / all the time?

Is your memory: Good / not very good / very impaired?

(*short and/or long term)*

Do you: Become agitated with your carers?

 Ever strike out at anyone?

Please list your pastimes/hobbies/interests:

Any other relevant information:

Do you receive Home Care? Yes/No Who is your Home Care provider?

Would you like to receive information about other Horsfall House services? Home Care

Nursing Home

Signed: Date:

(Print Name)

Relationship to applicant if signed on their behalf:

Where did you hear about Horsfall House?

Please return to: Day Centre, Horsfall House, Windmill Road, Minchinhampton, Glos, GL6 9EY