

## Adult Services

St Elizabeth’s Centre

Hertfordshire

SG10 6EW

Tel: 01279 843451

Tel: 01279 844221 (office)

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[www.stelizabeths.org.uk](http://www.stelizabeths.org.uk)

## PLEASE COMPLETE IN CAPITAL LETTERS USING BLACK INK AND RETURN TO ADMISSIONS AT THE ABOVE ADDRESS

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| **St Elizabeth’s Home Application/Assessment Information** | | | | | | |
| **Name:** |  | | **Likes to be known as:** | |  |
| **DOB:** |  | | **Service/s required** | Day service □ Respite□ Residential □ | |
| **Current Address:** | |  | **Requested date of admission:** | Month……………………. Year ………….. | |
|  | |  | **Contact No:** |  | |
|  | |  | **Mobile:** |  | |
|  | |  | **National Ins. No:** |  | |
|  | |  | **Ethnicity:** |  | |

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| **Full address of NOK (if different from above)** |  | **NOK Name/s:** |  |
|  | **Home Tel. No:** |  |
| **Mobile No.:** |  |
| **E mail Address:** |  |

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| **Funding Authority: (social services/PCT, joint funded, private etc:** |  | | |
| **Named contact person & address:** |  | | |
| **Telephone No:** |  | **e-mail address:** |  |

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| **General Practitioner (GP) Name:** | |  | | |
| **Address:** |  | | **Contact No:** |  |
|  | **Email Address:** |  |
| **Fax No:** |  |

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| **Connections Advisor (if applicable) Name:** | |  | | |
| **Address:** |  | | **Contact No.:** |  |
|  | **Email Address:** |  |
| **Fax No.:** |  |

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| **Medical Diagnosis: *(Please include type and frequency of seizures)*** |
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| **Seizure Information** | | | | | |
| **Before** a seizure I usually: | |  | | | |
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| **After** a seizure I usually: | |  | | | |
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| I have seizures at night | | **Yes / No** | If YES please tell us about the frequency and type of seizures: | | |
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| Date of last EEG: |  | | | Result |  |
| Date of last MRI scan: |  | | | Result |  |
| Other information relevant to seizure management: *( for example: intervention medication)* | | | | | |
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| **Medication:** | | |
| Drug name | **Dosage** | Time/s given |
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**Epilepsy Classification** (please tick all that apply): Active

In remission (on medication)

In remission (off medication)

Single seizure

Non-epileptic (associated disorder)

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| Age at first seizure:…… | Most recent seizure:………………… | No of seizures in last 12mths:…… |

**Epilepsy Classification** (please tick all that apply) **Seizure Classification** (please tick all that apply)

Partial epilepsy Tonic/Clonic (includes tonic or clonic)

Generalised epilepsy Absences

Primary generalised Myoclonic Jerks

Secondary generalised Drop attacks

Specific Syndrome Complex partial seizures

Simple partial seizures

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| **Mobility:** | | | | |
| I can walk independently | **Yes / No** | | | |
| I need help with: |  | | | |
| I use these aids to help me: |  | | | |
| When I go out I need help to get about: (please specify help required) | | | |  |
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| I have fallen in the last 12 months | | **Yes / No** | | |
| The reason/s I have fallen are: | |  | | |
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| Previous fractures:  If YES what was broken & when: | | |  | |
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| I have a history of Osteoporosis | | **Yes / No** | | |

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| Physiotherapy: | |
| I am currently receiving Physiotherapy | Yes / No ....... hours per week |
| If YES please tell us why and how often you receive the service |  |
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| **Sensory Assessment:** | | |
| I have difficulty with my vision | **Yes / No** | |
| I wear glasses | **Yes / No** | |
| I have other visual difficulties (please specify) | |  |
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| **Hearing:** | | |
| I have difficulty with my hearing | **Yes / No** | |
| I use hearing aid/s | **Yes / No** | |
| I have other difficulties with my hearing (please describe) | |  |
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| **Mental Health:** | |
| I have experienced difficulties with my mental health | **Yes / No State which service:** |
| I am under the care of a psychiatrist or psychologist | **Yes / No**  **....... hours per week** |
| At times I need help with behaviour management | **Yes / No** |
| If **Yes to any of the above**, please describe help/present input |  |
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| **Continence:** | | |
| I am usually continent of urine | | **Yes / No** |
| I can usually control my bowel movements | | **Yes / No** |
| I wear pads during the day | | **Yes / No** |
| I wear pads during the night | | **Yes / No** |
| I wear pads when I go out | | **Yes / No** |
| I only have continence difficulties during seizures / epileptic activity | | **Yes / No** |
| Other information: (e.g. urinary infections) |  | |
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| **Allergies:** |  |
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| **Dietary Information:** | | | |
| My current weight is: | \_\_\_\_\_\_\_\_\_ **Kg** | | |
| I have special dietary requirements | | | **Yes / No** |
| If **Yes,** please specify requirements | |  | |
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| Immunisation Details |  | |
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| Date of Last Tetanus Injection | |  |

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| **Sleeping:** | | | | |
| Do you have difficulties settling at night |  | | **Yes / No** | |
| If YES please tell us what the difficulties are and how they are helped | | |  | |
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| Do you usually wake during the night |  |  | | **Yes / No** |
| If YES state what wakes you, how often and what resettles you | |  | |  |
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| **Speech:** | |
| I am currently receiving Speech Therapy | **Yes / No ....... hours per week** |
| If YES please tell us why and how often you receive the service |  |
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| **Occupational Therapy:** | |
| I am currently receiving Occupational Therapy | **Yes / No ....... hours per week** |
| If YES please tell us why and how often you receive the service |  |
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| **Please list the names of Medical Personnel you are currently receiving a service from (i.e. Neurology)** | | | |
| Name | Position | Organisation Address | How often seen |
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*Separate page if necessary*

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| **Cultural / Spiritual Needs:** | | | | | | | |
| I have a specific faith | | | | **Yes / No** | | | |
| If **Yes,** please state whichfaith group you belong to: | | | |  | | | |
| I like to attend services in relation to my faith / beliefs | | | | **Yes / No** | | | |
| Please tell us what you would like to attend and any support you may need to assist. | | | | | | |  |
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| I have special days in the year that I wish to celebrate ( please describe) | | | | | |  | |
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| My first language is English | | | **Yes / No** | | | | |
| I speak or understand other languages | | | **Yes / No** | | | | |
| If **Yes,** please tell us of otherlanguages you speak or understand | | | | |  | | |
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| **Is there any other information you feel we need to know about relevant to your application? Please use this space to tell us** | | | | | | | |
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| **Name and address/contact details of person completing form:**  **(If different to front page)** |  | | | | | |
| Relation to applicant: |  | | | | | |

Date form completed …………………………

Thank you for the completion and return of this information.