Ridleyton Greek Home for the Aged (Reg)

MEDICAL CERTIFICATE

1. APPLICANT'S NAME: .... SURNAME: ....
   DATE OF BIRTH: .... AGE: ....

2. ARE YOU THE APPLICANT'S USUAL DOCTOR? ☐ YES ☐ NO
   HOW LONG HAVE YOU KNOWN THE APPLICANT? ....

3. SIGNIFICANT PAST MEDICAL/SURGICAL HISTORY AND YEAR DIAGNOSED (If not covered below):

4. PRESENT PROBLEMS AND YEAR DIAGNOSED (if any):

5. CURRENT MEDICATION (Dosage and Frequency):

6. ALLERGIES: ☐ Yes ☐ No (If Yes list)..

7. IMMUNISATION STATUS: Date of last Influenza Vaccination ....
   Date of Last Pneumovax date of (Pneunococcal polysaccharide (23vPPV..................
   List other relevant immunisation information: ....

8. EXAMINATION:
   8.1 Blood Pressure .... Thalassemia ☐ Yes ☐ No
   8.2 Are there any indications of any heart or vascular disease? ☐ Yes ☐ No
   If yes, give details: ....
   8.3 Are there any indications of disease of the respiratory system ☐ Yes ☐ No
   If yes, give details: ....

8.4 Any history or evidence of tuberculosis? ☐ Yes ☐ No

If yes, give details: ....

8.5 Are there any indication of disease of the digestive system or bowel? ☐ Yes ☐ No

If yes, give details: ....

8.6 Does the applicant require any special diet? ☐ Yes ☐ No

If yes, give details: ....

8.7 Are there any indications of any disease of the genito-urinary system? ☐ Yes ☐ No

If yes, give details: ....

Urinary/Faecal Incontinence. Date and Type of Investigations/Remedy:

....

8.8 Is there any evidence of diabetes? ☐ Yes ☐ No

If yes, give details: ....

8.9 Are there any indications of disease of the Neuro-Hormonal System? ☐ Yes ☐ No

If yes, give details: ....

8.10 Any history of Epilepsy? ☐ Yes ☐ No

If yes, give details: ....

8.11 Is the applicant mentally competent? ☐ Yes ☐ No

If no, give details: ....

8.12 Is there any evidence of (a) anxiety, (b) depression, (c) dementia, (d) alzheimers? ☐ Yes ☐ No

If yes, give details: ....

Has the applicant been assessed by a Geriatrician/Psychogeriatrician?

If yes, please forward report with application.

8.13 Are there any significant Sensory Impairments (hearing, vision, speech, language)

(a) Hearing .... (b) Vision ....

(c) Speech .... (d) Language ....

8.14 Are there any diseases of the skeletal system? ☐ Yes ☐ No

If yes, give details: ....

8.15 (a) Past fractures (specify/indicate year): ....

(b) Prosthesis (specify/indicate year): ....

(c) Arthritis: ....

8.16 Are there any significant dermatological conditions? ☐ Yes ☐ No

If yes, give details: ....

8.17 Is there anything about the physical or mental condition of the applicant, not clearly shown above, which you consider should be known by the Home when considering this application for admission? ☐ Yes ☐ No

If yes, give details: ....

6.18 Are there any social needs which would be taken into consideration? ☐ Yes ☐ No

If yes, give details: ....

....

....

....

Doctor's Name: .... Signature: .... Date: ....

Address: .... Phone: ....

SUPPLEMENTARY MEDICAL ASSESSMENT

(Please tick in appropriate square)

9. MOBILITY

7.1 AMBULATION:
- ☐ Unassisted
- ☐ With Walking Aid
- ☐ With help of another person
- ☐ With help of 2 persons

7.2 TRANSFERRING
- ☐ Out of bed without help
- ☐ Out of bed with help
- ☐ Chairfast
- ☐ Bedfast

10. PERSONAL HYGIENE/SHOWER

8.1 SHOWER:
- ☐ Independently
- ☐ With Supervision
- ☐ With Minimal Help
- ☐ With Constant Help

8.2 DRESS:
- ☐ Independently
- ☐ With Supervision
- ☐ With Minimal Help
- ☐ With Constant Help

8.3 GROOM:
- ☐ Independently
- ☐ With Supervision
- ☐ With Minimal Help
- ☐ With Constant Help

11. CONTINENCE

9.1 URINE:
- ☐ Continent
- ☐ Incontinent (but not daily)
- ☐ Incontinent (once daily)
- ☐ Incontinent frequently

9.2 FAECES:
- ☐ Continent
- ☐ Incontinent (but not daily)
- ☐ Incontinent (once daily)
- ☐ Incontinent frequently

Bowel Evacuation Management: ....

12. MEDICATION
- ☐ Manages Independently
- ☐ Requires Organisation
- ☐ Requires Full Supervision

13. MEALS
- ☐ Manages Independently
- ☐ Needs help cutting up food
- ☐ Needs to be fed
- ☐ Has difficulty in Mastication
- ☐ Has difficulty Swallowing

14. BEHAVIOUR

Confusion: ....
- ☐ Hostility / Intrusive
- ☐ Wandering (safety needs)
- ☐ Sleep / Nocturnal disturbance
- ☐ Other ....

Mood Affect: ....
- ☐ Short Term Memory Loss
- ☐ Long Term Memory Loss
- ☐ Danger to Self
- ☐ Danger to Others
- ☐ Needs Constant Supervision
- ☐ Needs Psychogeriatric Assessment

Repetitive Behaviour: ....

Requires prompting with activities of living (presentation of Dementia/Alzheimers): ☐ Yes ☐ No

15. ACUTE/CHRONIC PAIN MANAGEMENT ☐ Yes ☐ No

Specify: ....

Investigations: ....

Management: ....

16. SMOKER ☐ Yes ☐ No

(RGHA IS A NON SMOKING FACILITY)

ALCOHOL USE/ABUSE ☐ Yes ☐ No

17. OTHER COMMENTS

Specify the reasons you believe Low Level Care – Hostel or High Level Care – Nursing Home care is urgent including details of any Social status)

....

....

....

18. **AGED CARE ASSESSMENT TEAM (ACAT)** **Approval:** ☐ Yes ☐ No

Approved By: .... Date Approved: ....

Approved For: ☐ High Level of Care ☐ Low Level of Care

☐ Permanent ☐ Respite

Significant Family Support:

....

....

....

19. **COMMUNITY SUPPORTS USED**

☐ No Community Support Needed
☐ Maximum Available Need but not used
☐ RDNS
☐ Maximum Available Used but Inadequate
☐ Meals on Wheels
☐ Domiciliary Services

20. **PRESENT ACCOMMODATION**

☐ Has home that is secure/long term
☐ Has home that is insecure/temporary

21. **FAMILY AND PRIVATE SUPPORTS**

☐ Functioning Well
☐ Socially Isolated/fear of living alone
☐ Not Functioning Well (too stressed)
☐ Socially Isolated/safety at risk

PLEASE RETURN BOTH THESE FORMS TO THE ADMISSIONS OFFICER
RIDLEYTON GREEK HOME FOR THE AGED
89 HAWKER STREET
BROMPTON SA 5007