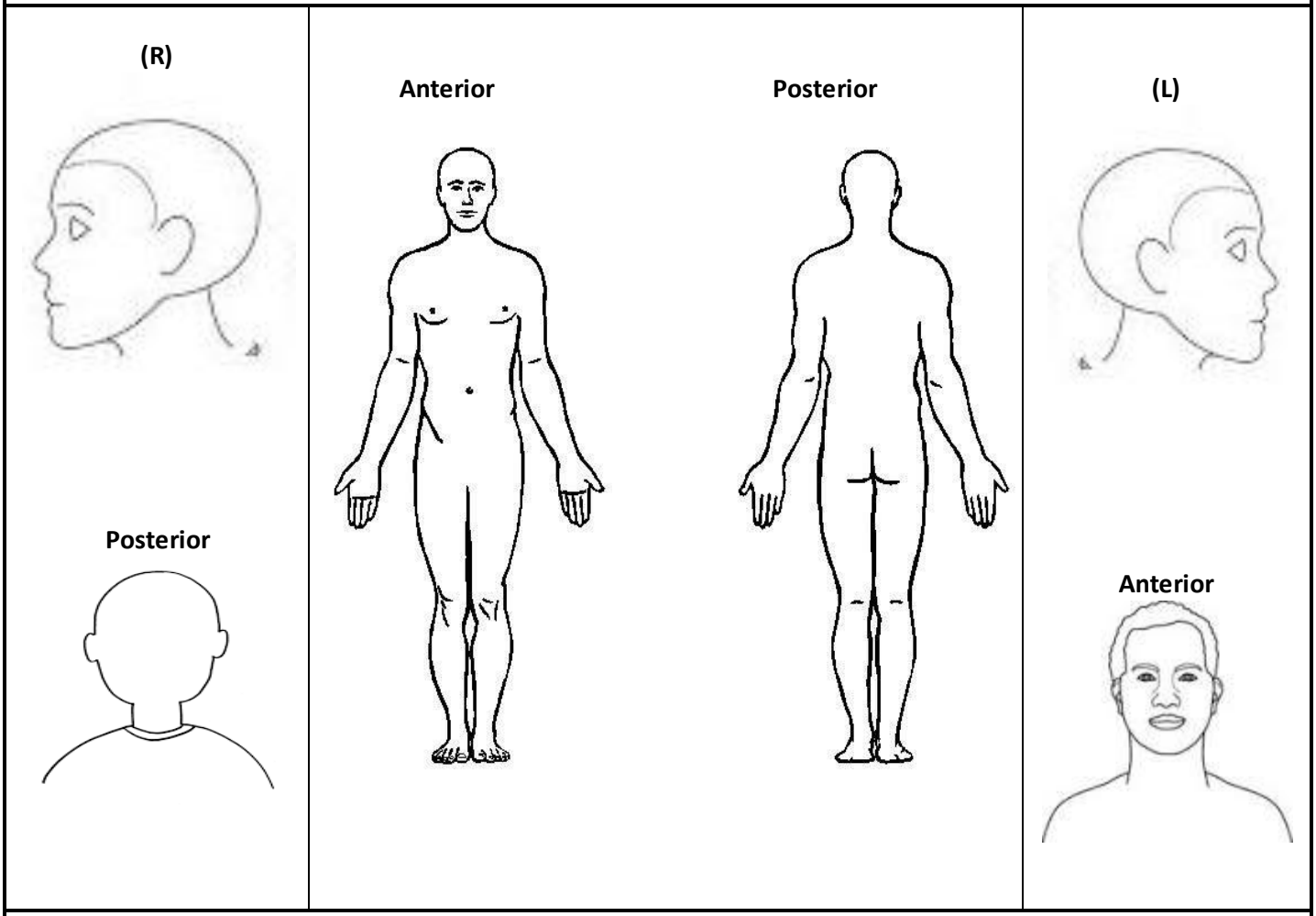
PERSON CENTERED ADMISSION RECORD

RESIDENT INFORMATION		SPOUSE INFORMATION		
Surname		Spouse		ID No:
Name		Full names:		
Initials		Surname:		
Title		ID no:		
Gender		Home tel no and code:		
RSA ID Number:		Work tel no and code:		
Medical Aid:		Cell no:		
Medical Aid Number:		Postal Address:		
Option:				
Hospital Plan:				
Number:				
Ambulance Service:		Area Code:		
1. Contact person for an emergency		E-mail address:		
Name				
Surname				
Relationship		Treating Medical Practitioner (GP):		
Tel/Cell no		Initials and Surname		Resident:
E-mail		Practice Number:		
Residential living area e.g. JHB, PTA		Telephone No:		
2. Contact person for an emergency		E-mail Address:		
Name		1. Specialist Medical Practitioner:		
Surname		Initials and Surname		
Relationship		Speciality:		
Tel/Cell no		Telephone No:		
E-Mail		E-mail Address:		
Residential living area e.g. JHB, PTA		2. Specialist Medical Practitioner:		
3. Next of Kin 1		Initials and Surname:		
Name		Telephone No:		
Surname		E-mail Address:		
Relationship		In case of Admission – Hospital of Choice:		
Tel/Cell no		1.		
E-mail				
Residential living area e.g. JHB, PTA		2.		
4. Guarantor Details				
Name		3.		
Surname		OTHER MEDICAL ASSISTANCE		Date Admitted:
Relationship		DISCIPLINE	ADVISED	
Tel		Physiotherapist:		
E-mail		Name		
Residential living area e.g. JHB, PTA		Occupational Therapist:		
Primary Admission diagnosis:		Name		
		Dietician:		
		Name		
Current Complaints:		Religious Food Restrictions:		
		Speech Therapist:		
		Name		Time:
1. Pre Admission accommodation & history		Social Worker:		
• Lived alone •With family ☐		Name		
• Retirement village ☐ • Social Worker involved ☐		Clinical Counsellor		
LIVING WILL ATTACHED AND SIGNED ☐		Name		
2. DO NOT RESUSCITATE (DNR)		Funeral Home:		
YES ☐ or		Name		
NO ☐		a) Burial or ☐		
		b) Cremation ☐		

KDCUPrimary Admission and Baseline Assessment:	
Base Line Assessment on Admission	**Mode of Admission:**
Temperature °C	• **Walked unaided** ☐
Pulse _____ pm, Regular ☐ **or**	• **Walking Aid used** ☐
Irregular ☐	• **Wheelchair** ☐
Respiration _____rpm	• **Stretcher (ambulance)** ☐
SPO_2 (room air) %	**Allergy History (record with a Red Pen)**
Urinalysis:	• **Medication:**
Hb: HGT:	
L.O.C.	
Diet: Full ☐ Special ☐ Liquid ☐	
Naso/Peg ☐	• **Chemical & other substances e.g. Iodene, Betadine, Plaster, etc.**
General Appearance o/a Overweight ☐	
Under weight ☐ Frail ☐ Healthy ☐	
Body Mass: Kg	• **Food**
Length: meter	
Waist circumference : cm	• **Other (e.g. bee sting)**

Skin Assessment for Bruises and Pressure Ulcers O/A



1. Identify bruised areas with a Blue Pen and number Pressure Ulcers and mark with a Red Pen			
2. Circumference of each pressure ulcer: 1.		**2.**	**3.**
4.	**5.**	**6.**	
3. Skin Type:			
➢ **Healthy** ☐	➢ **Dry** ☐	➢ **Clammy (Temp)** ☐	➢ **Septicaemia** ☐
➢ **Tissue paper** ☐	➢ **Oedematous** ☐	➢ **Discoloured** ☐	➢ **Broken** ☐

Medical History	Yes	No	Give a short Description
1. Heart Disease (CCF; CT)			
2. Blood Pressure, High or Low (treatment)			
3. Varicose Veins/Thrombosis of Veins/Circulation			
4. Asthma, Bronchitis, TB other lung disease			
5. Jaundice/other liver conditions e.g. Hepatitis			
6. Diabetes Mellitus			
7. Thyroid condition			
8. Gastric/Duodenal Ulcer, Hiatus Hernia			
9. Porphyria (resident or family member)			
10. Genetic/Congenital History			
11. Epilepsy			
12. Neurological condition: MS, Parkinsons, Alzheimer, CVA, Blackouts			
13. Depression or Psychiatric Disorders			
14. Excessive bleeding after Tooth Extractions, Injury or Surgery			
15. Back/Neck problems e.g. Whiplash, Arthritis			
16. Any recent illness e.g. Cough or Cold			
17. Are you taking Steroids/Cortisone			
18. Are you on anticoagulant medication e.g. Warfarin			
19. Are you receiving Chemo/Radiation therapy			
20. Do you smoke			
21. Religious/Cultural considerations e.g. Blood Transfusion			
22. Diarrhoea episodes			
23. Constipation episodes			
24. Urinary catheter in situ (urethral or supra pubic)			
25. UTI episodes			

26. NG ☐or PEG tube ☐in situ	
27. AppetitePoor ☐ Average ☐	
28. Do you have a Pacemaker/Heart surgery? Type of pacemaker, date inserted surgeon name and date to be checked.	
29. Frequency of fall incidents:	

Surgical History:	Year and reason:
Mastectomy	
Prostatectomy	
Heart surgery	
Spinal surgery	
Hysterectomy	
Amputation of a limb	
Other:	

Mobility:	
Fully mobile/Totally independent	☐
Restless/Fidgety	☐
Ambulates with support and direct supervision	☐
Wheelchair bound	☐
Shop Rider	☐
Bed Bound	☐

Assessment of Resident's risk of falling	
Mobility:	
➢ Ambulates independently	0
➢ Uses assistive devices	1
➢ Requires assistance to ambulate	2
➢ Unable to Ambulate or transfer	3

Physical Risks & Deficits:				Level of Care Needed
Speech Deficit	Yes	Slightly	No	Independent ☐ Dependent ☐ Bedridden ☐
Visual Deficit	Blind	Glasses/Contact lenses	No	Pressure care ☐
				Care Aids Needed
Eating/Drinking Impairment	Peg tube	To be fed	No	Monkey chain ☐ Bed cradle ☐ Commode ☐
Catheter/Incontinent	Catheter	Nappies	No	Raised toilet seat ☐
Risk to Seizures	Epilepsy	Brain injury	No	Prosthesis on Admission:
Risk of Diabetic Coma	Type I	Type II	No	Glasses ☐
Risk of Bleeding	Warfarin	Disprin	None	Hearing Aid ☐
Fracture Risk	High	Medium	Low	Artificial Limb ☐
Bed Rest Embolism Risk	Previous	High Risk	Low	Contact Lenses ☐
Confused	Yes	No		Crowns ☐
Mood	Aggressive	Depressed	Positive	Dentures Top ☐ Bottom ☐
Pressure Ulcers	Current	High Risk	Low Risk	Other:
On O_2 concentrator	Yes ☐	No ☐		
Intermittent O_2 administration	Yes ☐	No ☐		
Hearing Aid Both Ears	Yes ☐	No ☐		DOCUMENTS TO ATTACH
Hearing Aid Left Ear	Yes ☐	No ☐		Copy of ID Document Yes ☐
Hearing Aid Right Ear	Yes ☐	No ☐		Copy of Medical Aid Card Yes ☐

Current Chronic Medication	
Name	Dosage

Current over the counter medication (OTC)	
Name	Dosage

I, the Resident/Guardian agree that the history and Information is complete, true and correct

Resident/Guardian Signature: _____

Professional Nurse: _____
Print Initials and Surname

LIVING WILL

I, the undersigned, _____

PRINTFULL NAMES AND SURNAME

IDENTITY NUMBER: _____

Presently residing in **PRETORIA**, declare this to be my Living Will.

1. DECLARATION

If the time comes when I can no longer make decisions regarding my future or health treatment, this Declaration stands as a testament of my wishes.

2. NO PROSPECT OF RECOVERY

If there is no reasonable prospect of recovery from physical illness or impairment which will cause me severe distress or render me incapable of rational existence, I request that I be allowed to die and not be kept alive by artificial means. I emphatically state that I wish to die in a natural manner.

3. USE OF DRUGS

It is my wish that I receive whatever quantity of drugs that may be required to **keep me free from pain** even if the moment of death is hastened.

4. REPRESENTATIVE

I appoint my _____ as my representative in the event of the circumstances as described if**Clause 2** above arises. He/she will have absolute discretion to take such decisions on my behalf as he/she deems fit. Identity Number: _____

5. **CONDONATIO**N

I direct any authority or authorative body of any nature whatsoever to condone the decisions of my representative and the actions of any medical practitioner acting on instructions of my representative.

6. FUNERAL ARRANGEMENTS

6.1 Burial	Yes	☐	or	No ☐
6.2 Cremation	Yes	☐	or	No ☐
6.3 Pacemaker in Situ	Yes	☐	or	No ☐

SIGNED at PRETORIA on this _____ day of _____, 20 _____, in the presence of the subscribing witnesses not related to me, all being present and signing at the same time in the presence of one another.

AS WITNESSES:

1. _____ _____

SIGNATURE TESTATOR

2. _____

NB! Attach a copy of the Identity Document of the Testator.