Thank you for taking the time to fill this in, it is in the best interests of the patient and allows for safe prescribing and clinical management.

Patient Forename(s) _____ Patient's Surname_____

Date of Birth_____ Name of Nursing/Care Home_____

Name of person completing this form _____Position_____

Signature of person completing the form_____

Next of Kin/family contacts

1. Name _____ Surname _____Telephone_____
2. Name _____ Surname _____Telephone_____
3. Name _____ Surname _____Telephone_____

Patients current condition: (circle the relevant statement please)

General Medical Condition: Stable / Unstable

Cognitive functions: Intact / Mildly impaired / Moderately impaired / Severely impaired

Behavioural issues: None / Minor / Agitated / Aggressive

Nursing Status: Residential/Nursing/EMI

Mobility: Full / With aids / With assistance / Immobile

Continence: Fully continent / Urinary incontinence / Faecal incontinence / Doubly incontinent

Any other issues that you feel that we should be aware of?

Patients Medical Conditions, please list any conditions regardless of their severity.

1. Diagnosis_____Severity_____Date of onset_____
2. Diagnosis_____Severity_____Date of onset_____
3. Diagnosis_____Severity_____Date of onset_____
4. Diagnosis_____Severity_____Date of onset_____
5. Diagnosis_____Severity_____Date of onset_____
6. Diagnosis_____Severity_____Date of onset_____
7. Diagnosis_____Severity_____Date of onset_____
8. Diagnosis_____Severity_____Date of onset_____
9. Diagnosis_____Severity_____Date of onset_____
10. Diagnosis_____Severity_____Date of onset_____
11. Diagnosis_____Severity_____Date of onset_____
12. Diagnosis_____Severity_____Date of onset_____
13. Diagnosis_____Severity_____Date of onset_____
14. Diagnosis_____Severity_____Date of onset_____

Allergies:

1. Allergic to _____ What happens?_____
2. Allergic to _____ What happens?_____
3. Allergic to _____ What happens?_____
4. Allergic to _____ What happens?_____

Medications used by patient:

(Include all medications including dressings, appliances, catheters and stoma care products)

Name of drug	Route (tablet / liquid/ injection / suppository / via tube)	Dose	Times taken	When started

Smoking Status

Marital Status

Recent Hospital Discharge?

Name of Hospital_____Ward_____Date Discharged_____Consultant_____

Alcohol questionnaire if appropriate:

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

THE SECTION BELOW APPLIES ONLY TO PATIENTS RECEIVING NURSING CARE OR EMI CARE AND NOT TO RESIDENTIAL PATIENTS:

Height

Weight

Blood Pressure

Pulse

Urinalysis

Sugar **Protein** **Blood** **Ketones** **White cells** **Nitrites**

Name of clinican performing measurements_____

Signature of clinican_____