Health
Sydney
Local Health District

CONCORD REPATRIATION GENERAL HOSPITAL

MY STORY

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Your Name: _____ Date: ____ /____ / ____

What is the preferred name of the person you care for? _____

Please list below family members or significant others that the patient may refer to during their stay in hospital. This will assist our staff to understand who they are talking about.

Name	Relationship to Patient	Town they live in

What was the patient's main occupation (past or present) eg. Housewife, Engineer

_____

Can the patient read? ☐ Yes ☐ No Can the patient write? ☐ Yes ☐ No

ACTIVITIES AND INTERESTS (please circle)

Sport: Golf / bowls / bridge / fishing / swimming / lifesaving / football / hockey / tai chi / horse riding / cricket / horse racing / other: _____

Other interests: Gardening / needlework / knitting / painting / drawing / pottery / cards / cooking / stamp collecting / singing / dancing / musical instrument / other – please state: _____

Favourite type of music:

Country / classical / opera / jazz / rock & roll / folk / pop / brass bands / other: _____

Favourite type of movies: Westerns / musicals / old movies / romances / comedy / documentaries / wildlife / sporting / dramas / murder mystery / other: _____

Favourite TV programs:

Live shows / police shows / news / current affairs / comedy / documentaries / other: _____

Preferred Radio Station: ABC / Radio National / 2EC / other: _____

Reading: Enjoys reading? ☐ Yes ☐ No Able to read independently? ☐ Yes ☐ No

Needs glasses to read? ☐ Yes ☐ No Would like someone to read to them? ☐ Yes ☐ No

Type of reading preferred: magazines / books / newspaper / other – please state: _____

Please list the patient's significant life experiences:

_____

_____

_____

_____

_____

_____

Adapted by Aged Care and Rehabilitation Services Concord Hospital 2013. References: Family Questionnaire Hornsby Hospital, Personal Profile Pambula Day Care, Carer-family Questionnaire (updated 2010) Cath Bateman, Dementia/Delirium CNC (2008), Bega Hospital Volunteer Form, Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD). A handbook for NSW Health Clinicians.

BINDING MARGIN – NO WRITING
FILE IN CLINICAL RECORD

MY STORY

MR XXX

ID 650887 Oct 13

Health
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Did the patient experience any War Service? _____

Where was the patient born?_____

How long have they lived in Australia? _____

List any travel experience or enjoyable holidays the patient had:

_____

_____

_____

Does the patient have any group or club memberships?

_____

_____

_____

What does the patient dislike doing?

_____

_____

Does the patient have a pet? ☐ Yes ☐ No If yes, name and type of pet _____

Does the patient sleep well at night? ☐ Yes ☐ No

If they are not sleeping well, what do you do to assist? _____

Is there a routine you use to help settle them?

_____

_____

_____

Is there anything that seems to make the patient more anxious/agitated or distress? eg. noise, time of day

If yes, please indicate what it is:

_____

_____

_____

Are there set routines you have developed that help reassure the patient? eg. with personal care, taking medication with meals

_____

_____

_____

Are there any repetitive questions or re-occurring issues that may need specific answers? eg. “I need to pay and I have no money”, “where is Mary”

_____

_____

_____

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NSW GOVERNMENT Health
Sydney Local Health District

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Are there any issues that may concern them during their stay in hospital? eg. worried about something or someone

_____

_____

_____

Are you aware of any signs or triggers that may indicate a need/want for something?

_____

_____

_____

When the patient is unsettled what are the things/tasks you do that help settle them? eg. cup of tea, put music on

_____

_____

_____

Do you or another family member wish to be contacted if they become increasingly confused? ☐ Yes ☐ No

If yes, nursing staff may ring you or another family member if the situation occurs, to enquire regarding your availability. You would not be under any obligation to attend unless it is convenient for you. Please indicate who you are happy for us to contact.

Name of Person to Contact	Contact Phone Number

What is the patient's favourite food? _____

Does the patient have any known food allergies or dislikes?

_____

_____

_____

What is the patient's preferred drink? ☐ Tea ☐ Coffee ☐ With milk ☐ Without milk ☐ Sugar

☐ Soft Drink ☐ Milk drinks ☐ Juice ☐ Supplements ☐ Other_____

Does the patient regularly drink alcohol? ☐ Yes ☐ No

☐ Beer ☐ Wine ☐ Spirits Type _____

How much alcohol does the patient drink per day?_____ glasses

Does the patient smoke? ☐ Yes ☐ No How many per day?_____

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Prior to admission, could the patient independently:

Shower/wash	☐ Yes	☐ No
Dress themselves	☐ Yes	☐ No
Go to the toilet	☐ Yes	☐ No
Walk safely	☐ Yes	☐ No
Eat without assistance	☐ Yes	☐ No
Make a telephone call	☐ Yes	☐ No
Drive a car	☐ Yes	☐ No

Does the patient currently use any aids:

☐ Hearing ☐ Walking ☐ Speech ☐ Glasses ☐ Other _____

Please indicate the patient's preference, if known:

☐ Basin Wash ☐ Shower ☐ Bath Time of day am/pm _____

Is constipation a concern for the patient? ☐ Yes ☐ No

Do they have a regime to manage their bowel regularity? _____

Is urinary continence a concern for the patient? ☐ Yes ☐ No

If yes how is this managed? _____

Please add any comments that you feel would be helpful to us in providing the best care for the person you care for while they are in hospital:

_____

_____

_____

_____

_____

_____

_____

The information you have provided about the person you care for may also be helpful for other services who provide their care after they have been discharged from hospital. Are you happy for us to share the information in this form with other services who will be providing care and support to the person you care for after their discharge from hospital?

☐ Yes ☐ No

Signature:_____ Print Name:_____ Date: ____ /____ / ____

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