Manilla Multi-Purpose Service
Residential Aged Care
Resident Profile
October 2016

NSW GOVERNMENT Health
Hunter New England
Local Health Network

Resident Information

Moving into residential aged care is a big step and we want to make that process as smooth as possible. Part of that process is finding out more about you. It is important for us gain an understanding of your likes and dislikes, social, family and cultural networks, as well your health care history and current care needs.

The information required in this form should be as current as possible. This is especially important for medical history, medications and care needs such as mobility and nutrition. A copy of any documents relating to recent admissions to hospital or a history from your General Practitioner is particularly useful.

You may find some of these questions very personal and all information gathered is confidential.

Personal Details

Surname: _____ Given Names: _____

Preferred Name: _____

Date of Birth: _____ / _____ / _____ Country of Birth: _____

Do you speak and/or understand English? Yes/No

If no, state languages spoken and understood: _____

Do you identify as Aboriginal or Torres Strait Islander? _____

Where did you spend most of your childhood? _____

Where did you spend most of your adult life? _____

What was your main occupation(s)? _____

Describe what you did as part of your work or some aspect of your work that you want us to know about? _____
_____

Did your work involve shift work? _____

Did you receive any awards or have any special experiences which you are particularly proud of? _____
_____

Did you have any military service or war time experiences? _____
_____

Are you affected by any past violent or stressful events? (This may include wars, political upheavals, violent or abusive situations, family tragedy).

_____
_____
_____

Family and Significant People

Mother's Name: _____ Father's Name: _____

Did/do you have any brothers or sisters? Yes/No. If yes:-

Name(s)
_____

Did you ever marry? Yes/No If yes, date ___ / ___ / ___

Place_____

Spouse's Name: _____ Occupation: _____

Do you have any children? Yes/No If yes Name(s) _____
_____

Do you have any grandchildren? Yes/No If yes Name(s) _____
_____
_____

Are there any other person(s) you are/were particularly close to? Yes/No.

If yes, please name, state relationship and give contact phone number: _____
_____

Pets

Do you have a pet at home?

If yes, please state type(s) and name(s) of the animals? _____
_____

Hobbies and Special Interests

Do you have any hobbies? Please list: _____
_____

Do you have any special requirement for undertaking these hobbies, such as: large print, padded brushes, assistance? _____
_____

Reading: Yes/No. If yes, describe types and favourite authors: _____
_____

Music: Yes/No. If yes, what type of music and band/singers do you like? _____

_____

Do you play a musical instrument? _____

Art: Yes/No. If yes do you like to paint, draw etc._____

Sport: Yes/No. If yes what sport did you play? _____

Games: Yes/No what type of games do you like? *(Include cards, board games, quizzes, bowls, competitions and level of participation)*_____

_____

T.V. / Radio: Yes/No. If yes, state which programmes / channels: _____

_____

Movies Yes/No. Do you have favourite movies? _____

_____

Other relevant interests or comments_____

_____

Social Relationships and Interests

Have you been an outgoing person, or one who prefers the company of just a few friends?

_____

_____

Were you involved in groups and clubs? (This information will help in the selection of group and individual activities)_____

_____

Important life events

Achievements, holidays, special memories (approximate dates would be helpful).

_____

_____

Comfort Needs

What are the special things you would like to do in your new home? *For example, foot massage, warm bath, back massage/scratch, glass of wine, reading in bed, listening to music, sing-a-longs, take-away food:* _____

_____

Do you have any special possessions that you would like to bring to your new home? *(Please discuss with staff)*_____

_____

Cultural and Spiritual Needs

Do you belong to a specific cultural group? _____

Do you follow the customs/considerations of the above group? If yes, please tell us about these._____

Do you observe or practice any religious or spiritual beliefs? If yes, describe these

_____

How are special cultural, spiritual events celebrated? (Name event and describe how that event is celebrated and what you may need to have us provide/observe for this event): _____

_____

_____

Advance Care Planning (ACP)

It is important for us to know what decisions you have made in regard to ongoing treatment for any illnesses that you may currently have, or may develop in the future.

This is called *Advance Care Planning (ACP).* Part of ACP is an early discussion with family / friends and appointing someone (substitute decision maker/person

responsible) who understands your wishes when you can no longer talk for yourself, or cannot understand the treatment required.

Have you and your family/friends discussed ACP? Yes/No

Have you written an Advanced Care Directive? Yes/No

Have you appointed an *'Enduring Guardian'* who can make decisions on your behalf in regard to your health care needs? Yes/No

_____

Have you appointed an *'Enduring Power of Attorney'* who can make decision about your financial matters on your behalf? Yes/No

_____

Do you have a Will? Yes / No

_____

Do you have a solicitor Yes / No

Please provide the name of solicitor and phone number

_____

Could you please include a copy of these documents with this package, including any advance care plan or care directive that you may have written.

Do you have any special wishes for your care when you die? _____

_____

Do you have specific cultural or religious actions that need to be completed prior to or after your death? _____

_____

Would you like to be buried or cremated? (Please circle)

Do you have a funeral director of choice?

_____

Do you have a pacemaker? Yes/No

Medical History

If you are able to obtain a *'health summary'* from your general practitioner, please include a copy when you return this pack.
Please list any medical conditions that you may have. _____

_____

Do you have any changes to your memory or cognition? Please describe _____

_____

_____

Please list any surgical procedures? Please include approximate year_____

_____

Please describe any complications from these operations? _____

_____

Do you have any allergies? _____

_____

Please list any medications you are currently prescribed by your G.P. (if no current health summary from your G.P.). _____

_____

_____

Please list over the counter medication not prescribed by your G.P. For example vitamins _____

Do you have the flu vaccine on an annual basis? Yes / No

When was your last flu vaccine? _____

Are you up-to-date with the pneumococcal vaccine (pneumonia) Yes/No?

We do recommend that you continue to have an annual flu vaccine.

TOILETING:

Do you need any assistance in any of the following aspects of using the toilet?

	YES	NO	Comment
Getting to the toilet			
Adjusting clothing			
Positioning on the toilet			
Personal hygiene (ie: wiping, hand washing)			

Help with continence aids (pads etc)			
Help with a care of a catheter			
Help with care of a colostomy			

Bowels

Do you have any problems with your bowels or has there been any recent change? Yes/No. Please describe _____

_____

Do you experience any abdominal pain or discomfort, or bloating? Yes/No
Please describe _____

_____

Do you experience any diarrhoea or loose bowel actions? Yes/No
Please describe _____

_____

Have you had any investigations for diarrhoea or loose bowel actions? Yes/No

Please describe _____

_____

Do you suffer from constipation? Yes/No

If yes, what do you do for your constipation (ie: diet, fluids, exercise etc), please include any medication you may take? _____

How well does it work? _____

Do you ever feel your bowel isn't empty and you need to go again? Yes/No

Have you ever seen blood in the toilet or on the paper after a bowel motion? Yes/No

What time of the day do you usually have a bowel movement? _____

Do you experience any bowel incontinence? Yes/No

Do you wear incontinence aids? Yes/No please describe: _____

_____

Bladder

Do you have any problems passing urine or has there been any recent change? Yes/No

Please describe:

_____

Do you experience any stress incontinence (dribbling of urine when you sneeze, cough or walk)? Yes / No

Please describe _____

_____

Do you experience any pain or burning when you pass urine? Yes / No.

If yes, have you had the cause investigated and what was the outcome. _____

_____

Do you need to get up at night? Yes/No If yes, how frequently? _____

SENSORY

Vision

Do you have any difficulties with your vision? Yes/No

Please describe _____

Do you wear glasses? Yes/No

What do you wear your glasses for? _____

Who is your eye specialist/optometrist, please detail, his/her name and address.

_____

_____

When did you last visit you eye specialist/optometrist?

_____

Do you have a follow up appointment please provide date:

_____

Date glasses last updated: _____

Do you require assistance to clean and put on your glasses? _____

If possible, could you please label your glasses with your name or other identifying feature prior to moving in.

Hearing:

Do you experience any difficulties with your hearing? Yes/No please describe: ____
_____

Do you wear aids to help your hearing? Yes/No

Left ear____ Right ear ____ Both ears___

Do you wear hearing aids all the time? Yes/No

Do you need any help to put them in place? Yes/No

Who is your hearing aid provider?
_____

Speech

Please describe any difficulties you may have with your speech? _____

_____

Do you have difficulty understanding others? Yes/No

If yes what causes the difficulty _____

In instances of a second language an interpreter maybe used to help us provide appropriate care.

Physical Matters and mobility

Do you have any physical problems that prevent you from mobilising independently or safely Yes/No

If yes, tell us about those problems_____

_____

Do you have restricted movement in your arms and legs? Please describe

Arms _____

Legs _____

Can you walk without assistance (this also includes walking with the aid of frame or stick)? Yes/No

Describe _____

How far can you walk with out assistance? _____

Please describe any additional assistance you may need to help you walk (this may include a person to walk beside you)_____

_____

Please indicate how much assistance you need or describe any aids you use to do the following:

Get into and out of bed:

_____

Move about in bed (roll over or change position):

_____

Get in and out of a chair:

_____

Negotiate doorways or move around a room:

_____

Have you had any falls within the last twelve months? Yes/No

What were the circumstances of the falls?

_____

_____

Personal hygiene and grooming

Do you prefer to have a bath or a shower? _____

At what time of the day do you like to shower/bath? _____

How often do you like to bath or shower? _____

Are you able to bath/shower independently? Yes/No

If you require aids to shower / bath independently please describe. _____

_____

Do you need any additional assistance in the bath or shower? Yes/No

Please describe _____

Do you use any special soaps or creams when you shower? Yes/No

Please describe _____

How often do you wash your hair? _____

How often do you shave? _____ Do you use after-shave? Yes/No

Are you able to dress and undress independently? Yes/No

Do you wear dentures? Yes/No Please describe Top/Bottom/Partial Plate

Do you leave them in at night? Yes/No

Do you require assistance to clean your teeth? Yes/No

Describe_____

Do you require assistance to Comb your hair? Yes/No

Describe_____

Do you require assistance to care for your finger and toe nails: Yes/No

Describe: _____

Do you see a podiatrist on a regular basis? Yes/No

Name _____

Personal Routines and Preferences

Please indicate your preferences.

How often do you have your haircut? _____

What do you like done with your hair – perm, colour, and blow dry etc?

Please describe _____

If you have a moustache/beard how often is it trimmed? _____

What are your special likes / dislikes regarding makeup, skin care/facial hair removal, finger nail care and clothing? _____

_____

_____

Do you like to wear any accessories each day, such as belts, bow-ties, cravats, scarf jewellery? _____

_____

What sort of footwear do you like to wear? _____

We recommend firm fitting, closed toe shoes with a low heel with a non-slip sole or non-slip socks to walk with safety.

Are there any items of clothing that you do not like to wear?

Please describe_____

Do you like to drink alcohol? Yes/No. If yes, what type and when? _____

_____

Any additional information: _____

_____

Diet:

This page should be copied and forwarded to the hospital kitchen

Special dietary requirements

None □ Vegetarian □ Diabetic □ Puree □ Soft □ Minced □

If other type of diet please specifies: _____

_____

Do you have any spiritual and/or cultural requirements for your diet (halal, no pork etc)? Yes/No_____

Please describe any difficulties you have swallowing your meals or drinks? _____

_____

Have you been referred to a speech pathologist or dietitian? Yes / No Please provide any recommendations from these visits_____

_____

Do you have any food allergies? Yes/No please list: _____

_____

Do you currently require help or use any aides to help you drink or eat your meals?

Example special crockery or cutlery, plate guard, non-slip mat. Yes/No

Please describe: _____

Tell us about your food likes and dislikes _____

_____

Do you like to eat breakfast? Yes / No _____

Do you like to eat alone or in the company of others? Yes / No _____

_____

What are your favourite foods? _____

What foods do you dislike? _____

Do you have any special dietary requirements in relation to fluids? (For example sweetener; fluid thickener; no milk products: _____

Do you drink tea/coffee, Milo or other drinks? Please list and include any additives you might have such as milk, sugar, and sweetener: _____

_____

Pain

Do you experience any chronic or debilitating episodes of pain? Please describe:

_____

_____

_____

What do you do to relieve this pain? _____

_____

_____

Is there anything that makes the pain worse? _____

_____

Is there anything else we need to know about your pain? _____

_____

What do you do to relieve minor, intermittent pain, such as a headache or joint discomfort? _____

_____

Sleep

Do you experience difficulties with sleeping? Yes / No

Please describe what helps you to sleep better? For example medication, hot toddy:

_____

Please describe anything that makes you sleep poorly? Describe: _____

_____

What do you like to wear to bed? _____

What time do you usually go to bed? _____

What time do you usually wake up? _____

How many pillows do you like? _____

Hospital beds come fitted with bed rails would you like them up or down? _____

Have you ever had a pressure injury? Yes/No

Describe_____

Strategies to provide safe care

Are there things or situations that may cause distress e.g. colours, events in your life etc. _____

If unsettled are there words or actions that will help settle and calm? e.g. listening to music, relocation, reading and lighting Please describe: _____

_____

_____

Are there any repetitive questions or reoccurring issues that may need specific answers? What is the preferred answer? _____

_____

Is there somebody that maybe called out for? This could be a person or pet.

_____

_____

Are there signs that indicate a need or want? e.g. fidgeting to indicate a need to go to the toilet _____

_____

_____

Has there been an occasion when you have not been able to find your way home? Yes/No

Describe_____

Is there anything we should know that would help us to make you feel safe?_____

_____

_____

Additional information or concerns:

Please write down any additional information or concerns that you or your carer/family may have. This may include issues that you want clarified or anything that you would like us to know about yourself.

_____

_____

Thank you for completing this document.

This document has been completed in conjunction with:

Print your name ____________________ (Signature) _________________________

Date: _____ / _____ / _____

Family member or Guardian/Person Responsible

Print Name _____ (Signature) _____

Relation to you: _____

Date: _____ / _____ / _____

Reviewed and discussed with resident/family/carer by:

(Name & Signature of Nurse) _____

Date: _____ / _____ / _____