Application for Admission to Clevis Welfare Home

Please return form to: Chair Person of Selection Committee,
The Clevis Welfare Home, Leopardstown Park Hospital,
Foxrock, Dublin 18. Tel: 01 – 2160555 Fax: 01-2160554

SECTION 1

To be completed by or on behalf of applicant

Name: -- **Preferred Name:**--

Date of Birth: -- **Married/Single/Widow/Widower:** --------------------

Medical Card No: -- **PPS No:**--

Address: --

Telephone: -- **Mobile:**--

Email--

NEXT OF KIN 1 / CONTACT PERSON

Name: -- **Relationship to Applicant:** --------------------

Address: --

Telephone: -- **Mobile:**--

Email--

NEXT OF KIN 2

Name: -- **Relationship to Applicant:** --------------------

Address: --

Telephone: -- **Mobile:**--

Email--

GP DETAILS

G.P. Name: -- **Telephone:** ------------------------------

Address: --

PARTICULARS OF INCOME

Social Welfare Benefit/Pensions: --

Retirement pension from former employment or that of spouse: --

Any other income: --

ALL APPLICANTS DEEMED SUITABLE FOR TRIAL ADMISSION WILL BE REQUESTED TO SUBMIT A FINANCIAL ASSESSMENT FORM TO ESTABLISH CONTRIBUTION FEES
Fees charged at 80% assessable income minus allowable deductibles

REASON FOR APPLICATION --

Signed (by or on behalf of applicant) --**Date:** ---------------------

If not completed by applicant, please state reason and relationship to applicant: ------------------------------

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SECTION 2

To be completed by the Public Health Nurse or Social Worker

Have you confirmed the above information------------------------- **Application initiated by:** ----------------

Current Accomodation:

Whole house/flat/other------------------**Owner occupied/rented**----------------------**Living Alone**----------------------

Last seen by visiting relative: --

Applicant's capacity for self-care:

Dressing: ------------------------------------ **Bathing:** ------------------------------------

Cooking------------------------------------ **Laundry**------------------------------------

House-care------------------------------------ **Shopping**------------------------------------

MOBILITY: Independent: ---------------- **Stick** ------------- **Frame:** ---------------------- **Other:** -------------------------

CURRENT COMMUNITY/HOME CARE SUPPORT SERVICES

Service (Tick)	Home Help/Support	Day Centre	Respite	Meals Supply	CMHN	PHN
Hours/Times p/w or relevant time or if refused						
Service (Tick)	Family Support	Private Carer	Therapy / otherDiscipline	Retirement Groups	Day Hospital	Services Refused
Hours/Times p/w or relevant time or if refused						

Signed: ------------------------------ **Date:** ---------------**Agency:** ---------------------- **Telephone:** --------------------------

SECTION 3

To be completed by Applicants G.P

Present complaints (if any) --

Medical/Mental health /History ----------- ---

Mobility: Independent: ---------------- **Stick** ------------- **Frame:** ---------------------- **Other:** --------------------------

Falls History --

Nutrition **Adequate/Inadequate** ---------------------------**Weight Kgs** ------------ **Weight loss in last 6 months Y / N**

Hearing **Normal/Impaired** -- **Hearing Aids Y / N**

Speech **Normal/Impaired** --

Vision **Normal/Impaired** --

Skin --

Continence--

Communication --

Cognitive Ability --- **MMSE** ---------------**Date:**-----------

Current Medications

Name of Drug	Dosage	Frequency

PRINT NAME:--**Signed** ---

Practice -- --------------------------**Date** ------------------------------------

<u>ALL APPLICATIONS MUST BE ACCOMPANED BY A REPORT FROM A GERIATRICIAN FOLLOWING A RECENT ASSESSMENT (last 6 months)</u>

ADDITIONAL REMARKS

OTHER SIGNIFICANT MEDICAL/SOCIAL/ RISK FACTORS THAT SHOULD BE CONSIDERED

Signed -- **Date** ---------------------

Applicant/ GP/Public Health Nurse/CMHN/Social Worker