Resuscitation in an emergency

It is our practice to attempt resuscitation in an emergency unless there is clear evidence that this is not the patient's wish or the medical condition of the patient precludes it. Would you wish resuscitation to be attempted?

YES ☐ NO ☐ DISCUSS WITH DOCTOR ☐

We apologise for the direct nature of this question but we know that many patients like time to think about it/ discuss it with family and if we ask you on admission, it can be distressing when you are not expecting it.

Discharge arrangements

Are you going home on discharge from Burrswood? YES/NO

If no, please explain:

DATA PROTECTION

Burrswood is registered under the Data Protection Act. Your name and address will not be disclosed to any other organisation but we may, from time to time, contact you with information about our services and events by electronic mail, telephone or text. If you **do not** wish to receive this information, please tick this box. ☐

Team Confidentiality

Confidentiality is always strictly contained within the care of the team (doctors/nurses/chaplains, physiotherapists and counsellors) unless there is a danger to yourself or others. Relevant information for the team is recorded in the medical notes. Your booking to stay at Burrswood confirms your agreement to our team confidentiality.

- I confirm that the information given in this form is to the best of my knowledge true and fair
- I confirm my agreement to the above Team Confidentiality statement
- I consent to come to Burrswood and to be cared for at Burrswood

Patient's signature …… Date ……

If the patient is unable to sign the form, have they consented to come to Burrswood? YES/NO

Signed by …….. Date ……..
On behalf of the patient named on page 1

Please return the completed form to:-

The Admissions Office
Burrswood
Groombridge
Tunbridge Wells
Kent TN3 9PY

Tel: 01892 865988
Fax: 01892 862597
Email: admissions@burrswood.org.uk

If you have any queries, please do not hesitate to call us, we would be delighted to hear from you.

Patient's Admission Form

Burrswood
Health and Wellbeing

Details of the Patient

Title: Forename: Surname:

Address:

Postcode: Telephone no:

Religion (if any): Mobile no:

Denomination (if relevant): Email:

Age: Date of birth:

Marital status: Single/married/divorced/widowed/other _____

Length of stay required:

Preferred dates:

Coming from: Home/hospital/nursing home/other (please specify) _____

Current illness/reason for requesting admission:

What do you hope to gain from your stay?

How did you hear about Burrswood?

It is important that we can accurately assess your medical and nursing needs because this will help us to determine the most appropriate care package for you and the type of room best suited to you. Please complete the following details.

Your present condition

Are you:- (please indicate the one that most closely describes your current situation)

Completely self -caring for all day to day needs? ☐	In need of a little assistance with personal hygiene, washing and dressing? ☐	In need of one carer to assist with washing, dressing, personal hygiene, mobility and medication? ☐	In need of two carers to assist with washing, dressing, personal hygiene. Hoist dependent or need two to move? ☐

Bed bound? Yes/No

Able to press a nurse call bell? Yes/No

	YES	NO	If yes, please give details
Do you suffer from any incontinence?			
Are you suffering from any symptoms of memory loss/confusion?			
Do you need assistance to stand up?			
Do you need assistance to move from bed to chair?			
Do you need a hoist to move you?			
Do you need a special diet?			

Your next of kin

Title: Forename: Surname:

Address:

Postcode:

Telephone no:

Mobile no:

Email:

Relationship to patient:

Your GP

Dr: Initial:

Address:

Postcode:

Telephone no:

Fax no:

If you are completing this form on behalf of a patient but are not the next of kin, please give us your details:-

Title: Forename: Surname:

Address:

Telephone no:
Mobile no:
Email:

Postcode:

Your connection with the patient:

Please give us the details of other healthcare professionals involved in your care, eg consultants; counsellor/ psychiatrist; CPN; social worker or care manager.

Name	Role/Speciality	Contact details

I confirm that I am willing for you to contact the above, in confidence, if necessary.

Patient signature …….. Date …….