CONTINUING CARE PLACEMENT APPLICATION
DEPARTMENT OF MEDICINE
(DIVISION OF AGEING & THERAPEUTICS
&
DEPARTMENT OF OLD AGE PSYCHIATRY

Personal Details

Patient's Full Name	*Date of Birth/Age:*	*Admission Date:*
Address:	*Hospital/Home:*	*Ward:*
	Consultant:	*G.P.*
	Next of Kin/Principal Carer:	

Continuing Care Option Requested

Please tick (✓) appropriate box.

	Medicine	***Psychiatry***
Service required		

	St Camillus'	***St Ita's***
Continuing Care Bed		
Respite Bed		
Welfare Bed		

Medical Problem List

Problem	*Year*	*Problem*	*Year*
1…………………………………………	………………..	6…………………………………………	………………..
2…………………………………………	………………..	7…………………………………………	………………..
3…………………………………………	………………..	8…………………………………………	………………..
4…………………………………………	………………..	9…………………………………………	………………..
5…………………………………………	………………..	10……………………………………….	…………………

Current Medications

Drug	Dose	Freq	Drug	Dose	Freq
1………………………..	……………	…………	6………………………..	……………	…………
2………………………..	……………	…………	7………………………..	……………	…………
3………………………..	……………	…………	8………………………..	……………	…………
4………………………..	……………	…………	9………………………..	……………	…………
5………………………..	……………	…………	10………………………	……………	…………

Method of Administration: Self/Carer/Non compliant

Social Assessment *(Current or prior to hospitalisation)*

LIVES WITH: ……………………………………………

DEPENDENTS: ……………………………………………

HOUSING (type): ……………………………………………. ± STAIRS

CARERS: (Family/Friends) ……………………………………………..

HOME HELP: (frequency) ……………………………………………..

DAY CENTRE ATTENDANCE: …………………………………………….

PUBLIC HEALTH NURSE: …………………………CPN: ……………
(frequency and reason)

CLEANING: ………………………… LAUNDRY: ……………………..

SHOPPING: ……………………………. FINANCES: ………………………
(who pays bills?)

Functional Assessment

CURRENT ABILITY (Please tick the relevant box)

	Independent	*Assisted*	*Dependent*	*Aids*	*Type*
MOBILITY	☐	☐	☐	☐	………………
WASHING	☐	☐	☐	☐	
DRESSING	☐	☐	☐	☐	………………
COOKING	☐	☐	☐	☐	
FEEDING	☐	☐	☐	☐	………………

URINARY CONTINENCE (please circle) Continent Occasional Incontinent

FAECAL CONTINENCE (please circle) Continent Occasional Incontinent

Essential Functions

(please circle as appropriate)

Vision

GLASSES: Y/N

INTACT/PARTIALLY SIGHTED/BLIND

VISUAL ACUITY (WARD BASED):……../6

Hearing

HEARING AID: Y/N

INTACT/PARTIALLY DEAF/DEAF

Cognitive Assessment

1. Age
2. Time (nearest Hr)
3. Year
4. Place
5. Rec 2 people
6. DOB
7. Date WWII
8. Taoiseach
9. Count 20-1
10. Recall 2 people avove

Total ………/10

Medical or Psychiatric Summary

Signed ……………………… **Designation** Intern /SHO/Registrar/Consultant/GP **Date** …………

Nursing Summary

Signed ………………………… **Designation** Staff Nurse/Sister **Date** ……………

INSTRUCTIONS

1. All applications to the Continuing Care Placement Panel must be accompanied by written notification that the patients case has been assessed and a conclusion reached by the Nursing Home Subvention Committee unless your patient falls into any of the following categories.

* the patient is terminally ill and has a prognosis that they are likely to die in the very near future.
* the patient requires intensive medical care which cannot be provided outside an inpatient environment, for example, those who require mechanical ventilation and cannot be maintained at home; have end-stage multiple sclerosis; have had an extensive stroke with loss of vital functions; or are unconscious and are in a persistent vegetative state.
* the patient requires intensive physical care, which cannot be provided outside of a protected inpatient environment, staffed by appropriately professionally qualified personnel e.g. recent onset of bulbar symptoms with aspiration risk or respiratory arrest.
* the patient requires intensive psychological care which cannot be provided outside a protected impatient environment. Examples include persons suffering from mental illness and incompletely resolved schizophrenia which requires specialist medical and nursing care
* the patient has a very high level of disturbed behaviour, placing themselves or others at substantial risk of harm.
* the patient has a violent response to care givers.

2. All applications to the Continuing Care Placement Panel will be considered within 14 days of receipt at the address below.

PLEASE RETURN:

A. THIS COMPLETED FORM

B. WRITTEN NOTIFICATION THAT THE PATIENTS CASE HAS BEEN ASSESSED AND A CONCLUSION REACHED BY THE NURSING HOME SUBVENTION COMMITTEE

TO **PLACEMENT PANEL OFFICE**
ST CAMILLUS HOSPITAL
SHELBOURNE ROAD
LIMERICK