

## **A Joint Project**

LIONS CLUB OF KUCHING HOST LIONS CLUB OF SERIAN LIONS CLUB OF KUCHING METRO LIONS CLUB OF KUCHING CITY LIONS CLUB OF KUCHING NORTH LIONS CLUB OF KUCHING IXORA LIONS CLUB OF KUCHING STAMPIN PENDING
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NEW CENTURY LIONS CLUB OF KUCHING EMERALD
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LIONS CLUB OF KUCHING KOTA SAMARAHAN
LIONS CLUB OF KUCHING KOTA SENTOSA
LIONS CLUB OF KUCHING CENTENNIAL

Patron: YBhg Dato Hjh Hannifah Hj. Taib Alsree Our Ref: Your Ref: Date: APPLICATION FOR ADMISSION TO LIONS NURSING HOME, KUCHING. Name: NRIC: Sex: Age: Marital Status: Date of Birth: \_\_\_\_ Dialect: \_\_\_\_\_ Religion: Race: **MEDICAL INFORMATION** Please complete the following sections as fully as possible and tick ( $\sqrt{\phantom{0}}$ ) where relevant. 1. **Diagnosis** History of illness Previous Hospitalization ( ) Yes, Hospital ( ) No. 2. Type(s) and date(s) of **operation**, if any **Allergies** (e.g food, medicine, others) ( ) Yes, Specify ( ) No. 3. **Present Treatment** Medication (give details) Dressing (give details) Physiotherapy ( ) Yes ( ) No (d) Occupational Therapy ( ) Yes ( ) No

4.	Does patient require	regular follow-up at Specialist Cl	linics?	( ) Yes	( ) No	
	If Yes, Specify					
5.	<b>Condition of Patier</b>	ıt				
	Is patient in constant pain and needs heavy sedation?			( ) Yes	( ) No	
	Physical State	<ul><li>( ) Satisfactory</li><li>( ) Respiratory disorders</li><li>( ) Others</li></ul>	( ) Weak ( ) Pain ( ) Drowsy ( ) Restless ( ) Impaired, specify		( ) Pale ( ) Dehydrated	
	Mental State	<ul><li>( ) Alert</li><li>( ) Confused</li><li>( ) Intact</li></ul>			( ) Anxious ( ) Others	
	Vision					
	Hearing	( ) Intact	( ) Impaire	ed, specify		
	Speech	( ) Normal	( ) Impaire	ed, specify		
	Skin	( ) Normal	( ) Impaire	ed, specify		
	Mouth	( ) Clean	( ) Ulcer		( ) Dentures	
	Joint Contractures	( ) Yes	( ) No			
	Others					
5.	<b>Mobility Status</b>					
	(a) Independent			( ) Yes	( ) No	
(	(b) Partially dependent (i.e. using aids, appliances, help, Give details if Yes		wheelchair)	( ) Yes	( ) No	
,	(c) Totally depende	nt		( ) Yes	( ) No	
7.	If Totally Dependen	nt (Non-Ambulant)				
	(i) Feeding		( ) Able to fe ( ) Needs ass ( ) Tube feed ( ) Others / S	sistance in feed ling	ling	

	(ii) Toilet	<ul> <li>( ) Able to attend to own toilet needs</li> <li>( ) Needs assistance in toilet needs</li> <li>( ) Incontinent of bladder</li> <li>( ) Incontinent of bowel</li> </ul>			
8.	Prognosis				
9.	If patient is currently in Hospital/ Institution, please submit a medical report from the Hospital/ Institution.				
10.	Any other relevant information.				
	Date	Signature of Attending Doctor			
		Name:			
		Address:			
		Tel:			

Please note that due to limited facilities at the Lions Nursing Home, the following type of cases may not be given priority for admission: -

- (i) Patients undergoing Radiotherapy.
- (ii) Patients with bed pressure sores requiring surgery.
- (iii) Patients who require regular follow-up at hospitals.
- (iv) Patients whose treatment requires laboratory monitoring.

## **SOCIAL INFORMATION**

1.	Patient has a home		( ) Yes		( ) No	
2.	Patient has a home but:					
	<ul> <li>( ) has no relatives or friends to help him/her</li> <li>( ) requires more care than is available at home</li> <li>( ) home conditions are unsuitable for his/her return from hospital</li> </ul>					
3.	Particulars of members of patient's family (including those living apart)					
	Name	Marital Status	Relationship To Patient	NRIC No	Occupation	Nett Monthly Income
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
4.	Name of person who will be Telephone No.)	responsible	for patient's Nursin	g Home Charges	(give also NRIC No	o. Address and
5.	Name of person to contact if	patient dies	(give also address an	d telephone no. if di	fferent from 4)	

6	Patient's financial status (gives reference number and amount if patient is receiving aid/pension. State amount if patient has savings)				
7.	Reasons for seeking admission				
8.	Length of stay (short-term or long-term)				
9. Whether relatives and friends are agreeable to discharge later on					
	Date	Signature of Guardian			
Notes	s:-				
(i)	This is a nursing home which provides rehabilitation ar – <b>not a Hospital.</b>	d basic nursing care for convalescing elderly Patients			
(ii)	You are encouraged to request your usual family doctor to come and provide follow-up treatment for th patient.				
(iii)	If any medicine is needed, you are to provide your own	medicine.			

## **DECISION OF MEDICAL BOARD**

Name of Applicant	:	
Diagnosis	<u>:</u>	
Admission	( ) Approved	( ) Not Approved
If not approved, reason	for rejection	
Doto		Cionatura of Attandina Danid Dantan
Date		Signature of Attending Board Doctor
		Name of Attending Board Doctor
Note to Attending Docto	or,	
Please fax hack this renl	y as soon as possible to (	082-461494 for I NH prompt action

AA-LNH Application for Admission Updated: 01/08/2017