



LIONS NURSING HOME

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 COSMOPOLITAN
 LIONS CLUB OF STAMPIN PENDING

LIONS CLUB OF KUCHING ALLAMANDA
 NEW CENTURY LIONS CLUB KUCHING EMERALD
 LIONS CLUB OF KUCHING IXORA
 LIONS CLUB OF BAU
 LIONS CLUB OF KUCHING HORNBILL
 LIONS CLUB OF KOTA SAMARAHAN

PATRON : DATUK AMAR PUAN SRI HAJJAH LAILA TAIB D.A.

Our Ref: _____

Your Ref: _____

Date: _____

APPLICATION FOR ADMISSION TO LIONS NURSING HOME, KUCHING

NAME: _____

NRIC: _____ SEX: _____ AGE: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____

RACE: _____ DIALECT: _____ RELIGION: _____

MEDICAL INFORMATION

Please complete the following sections as fully as possible and tick () where relevant.

1. **Diagnosis** _____

History of illness _____

Previous hospitalization () Yes, Hosp. _____
() No.

2. Type(s) and date(s) of **operation**, if any _____

Allergies (e.g. food, medicine, others.) () Yes, Specify _____
() No.

3. **Present treatment**

(a) Medication (give details) _____

(b) Dressing (give details) _____

(c) Physiotherapy () Yes () No

(d) Occupational Therapy () Yes () No

(1)

4. Does patient require regular follow-up at Specialist Clinics ? () Yes () No

Specify _____

5. **CONDITION OF PATIENT**

Is patient in constant pain and needs heavy sedation? () Yes () No

Physical State () Satisfactory () Weak () Pale
 () Respiratory disorders () Pain () Dehydrated
 () Others _____

Mental State () Alert () Drowsy () Anxious
 () Confused () Restless () Others _____

Vision () Intact () Impaired, specify _____

Hearing () Intact () Impaired, specify _____

Speech () Normal () Impaired, specify _____

Skin () Normal () Impaired, specify _____

Mouth () Clean () Ulcer () Dentures

Joint Contractures () Yes () No

Others _____

6. **MOBILITY STATUS**

(a) Independent () Yes () No

(b) Partially dependent () Yes () No
(i.e. using aids, appliances, help, wheelchair)
Give details if Yes

(c) Totally dependent () Yes () No

7. **IF TOTALLY DEPENDENT (NON-AMBULANT)**

(i) Feeding () Able to feed self.
 () Needs assistance in feeding.
 () Tube feeding.
 () Others/Specify _____

- (ii) Toilet
 - () Able to attend to own toilet needs.
 - () Needs assistance in toilet needs.
 - () Incontinent of bladder.
 - () Incontinent of bowel.

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 and 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:

- has no relatives or friends to help him/her
- requires more care than is available at home
- home conditions are unsuitable for his/her return from hospital

3. Particulars of members of patient's family (including those living apart)

NAME	MARITAL STATUS	RELATIONSHIP TO PATIENT	NRIC NO	OCCUPATION	NETT MONTHLY INCOME

4. Name of person who will be responsible for patient's Nursing Home Charges (give also NRIC No. Address and Telephone No.)

5. Name of person to contact if patient dies (give also address and telephone no. if different from 4)

6. Patient's financial status (give 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

- Note: (i) This is a nursing home which provides rehabilitation and basic nursing care for convalescing elderly Patients – **not a Hospital.**
- (ii) You are encouraged to request your usual family doctor to come and provide follow-up treatment for the patient.
- (iii) If any medicine is needed, you are to provide your own medicine.