

ADMISSION / APPLICATION FORM

NAME OF PATIENT

FORCE

HOME PREFERENCE: AUCHTERARDER / HARROGATE



NORTHERN POLICE CONVALESCENT AND TREATMENT CENTRE

St. Andrew's · Harlow Moor Road · Harrogate · North Yorkshire · HG2 0AD
Tel: 01423 504448 · Fax: 01423 527543

Castlebrae · Castleton Road · Auchterarder · Perthshire · PH3 1AG
Tel: 01764 664369 · Fax: 01764 664598

APPLICATION FOR ADMISSION

PART 1

TO BE COMPLETED BY PATIENT (Please print)

POLICE FORCE..... FORCE No.....

SERVING OFFICER/RETIRED OFFICER..... DATE OF BIRTH.....

(Delete as applicable)

MR/MRS/MISS/MS NAME

HOME ADDRESS

.....

.....

..... POST CODE

TELEPHONE No. (Include Code).....

SMOKER/NON SMOKER (Delete as applicable)

DATES TO AVOID (eg. Court appearances, Holidays etc)

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I understand that all information on this form will be confidential to the professional and administrative staff at the Centres.

Signature..... Date

TO BE COMPLETED BY FORCE REPRESENTATIVE

THE ABOVE NAMED IS/WAS (IN THE CASE OF A PENSIONER) A REGULAR SUBSCRIBER TO THE FUNDS OF THE HOME.

CERTIFIED BY (Signature).....

PRINT NAME..... TITLE.....

DEPARTMENT..... DATE.....

OTHER RELEVANT INFORMATION

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HIGHLY CONFIDENTIAL

PART 2

TO BE COMPLETED BY MEDICAL PRACTITIONER

1a) DIAGNOSIS

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1b) UNDERLYING CONDITIONS?

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1c) STRESS OR PSYCHIATRIC/PSYCHOLOGICAL? YES NO - If YES please complete Part 3 below

2) DATE OF ANY IN-PATIENT CARE.....

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3) NATURE AND DATES OF OPERATIONS/SCANS/X-RAYS (Please list)

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4a) LIMITED MOBILITY? YES NO - If YES please complete Part 3 overleaf

4b) IS NURSING ASSISTANCE REQUIRED WITH DAILY ROUTINE, AND IF SO PLEASE SPECIFY

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4c) DOES SPOUSE/HELPER NEED TO ATTEND? YES NO - If YES please complete Part 3 overleaf

5) MEDICATION/ALLERGIES/INFECTIONS YES NO - If YES please complete Part 3 overleaf

6) IS PHYSIOTHERAPY REQUIRED? YES NO - If YES please complete Part 3 overleaf

PART 3

STRESS/PSYCHOLOGICAL ETC: Please state fully any treatment or risk factors (i.e. prescribed drugs, alcohol abuse, self-harm risk). Please note there are NO psychiatric or counselling facilities at either Centre, therefore they are unsuitable for acute psychiatric illness.

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MOBILITY: Access requirements - can patient climb stairs/walk unaided/use wheelchair? Expand fully on assistance level if needed on a daily basis and if at risk from falling.

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SPOUSE/CARER: What level of care can spouse provide? Please give full details of patient's requirements and carer's capabilities.

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MEDICATION/ALLERGIES/INFECTIONS

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PHYSIOTHERAPY

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SIGNATURE OF MEDICAL PRACTITIONER

PLEASE PRINT NAME

ADDRESS

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TEL NO. DATE.....