

ADMISSION FORM

PATIENT'S NAME: SURNAME.....

AGE: SEX:

QZH NO: DATE OF ADMISSION:

PAST MEDICAL HISTORY:

.....

PAST SURGICAL HISTORY:

.....

.....

OBSTETRIC + GYNAECOLOGY HX:

.....

.....

.....

FAMILY AND SOCIAL HISTORY:

.....

.....

.....

PRESENT CONDITION:

.....

.....

OBSERVATION

TEMPERATURE: BP: PULSE:

WEIGHT: HGT:

MEDICATIONS:

.....

.....

QINA ZIMELE HOME

Reg: 212-113NPO

36 Henry Chartetton Street
Sonland Park,
Vereeniging,
1939

Mobile No: 076-602-4682
068 105 3476
E-mail:qinazimelehome@gmail.com

SOCIAL WORKER REPORT

1. Background History

2. Housing

3. Contributing factors that led to the application for admission:

— If neglect/abuse is the reason for application:

— What steps have been taken:

— Prevention or Legal steps have been taken:

4. Any disorders YES NO
 If YES, specify the psychiatric clinic or treatment centre
-
-

5. Any drug/alcohol dependency history YES NO
 IF YES, please specify previous treatment of the Centre/ Clinic.
-
-

6. General Mental Condition

- | | | |
|---------------------|------------------------------|-----------------------------|
| Mainly Clear | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Forgetful | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Disinterest | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Suicidal Tendencies | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
- IF YES, specify treatment and centre.
-
-

7. Social Contact

Family _____
 Church _____
 Community _____

8. Financial Circumstances

9. Alternative Care

Community Based Care YES NO
 If yes please specify

Meals on Wheels YES NO

Home Based Nursing Care YES NO

Other Homes/ Centres

Social Worker Signature

Print Name

Telephone No:

Date:

QINA ZIMELE HOME

INDEMNITY FORM

DATE:..... TIME:.....

I/We ,the undersigned, next of kin for:

(Full Name's and Surname) ID NO:.....

Hereby give my/our consent that the beneficiary (above), can take part in all activities organized by Qina Zimele Home. I/We further authorize the staff or responsible persons to act in oversee during activities and to give consent required by hospital medical authorities in respect of the medical attention they deem necessary. I/We also give consent for Qina Zimele Home to give care and administer medication per the Medical or Hospital staff instructions.

I/We absolve the **Qina Zimele Home**,staff and responsible person (absolute and irreclaimable) for any loss ,
Damage or Injury to(negligence and intention excluded) or effects arising from any
Reason whatsoever during activities.

As far as I/We know ,.....is not in a good state of mental/health. I/We do, however, request the responsible person to note the following :(state any particulars of your parents/grandparents state of health, allergies, medicine to be taken, and or activities in which he/she may not participate.).

I/We give my/our consent that medication sent by me, can be given to.....

By **Qina Zimele Home Nurse** according to the prescription. The **Qina Zimele Home Nurse** can treat

..... for any common illness and I/We absolve her/him from any after effects.

Full Name and Surname of Next of Kin:..... ID No:.....

Home Address:.....

Contact No's:..... Email:.....

Signature:..... Date:.....

QINA ZIMELE HOME

Reg: 212-113NPO

36 Henry Chartetton Street,

Sonland Park

Mobile No: 0766024682/068 105 3476

Email: qinazimelehome@gmail.com

The following Document must accompany the completed application for admission form:

1: Admission form

2: Copy of applicants Identity Document/Passport

3: Details of Next Kin

4: Financial Aspects

5: Referral Letter from previous clinic. (If on medication)

6: Social Workers Report

7: Copy of Funeral policy, if No policy a letter from the person who will be taking responsibility of funeral costs.

MEDICAL REPORT:

Personal details of the patient:

SURNAME	
FIRST NAMES	
DATE OF BIRTH	
AGE	
GENDER	

1. Medical History (major illnesses, including birth and family history if known)

(Handwriting area for medical history)

2. PHYSICAL EXAMINATION

2.1. General Appearance

(Handwriting area for general appearance)

2.2. Skin

(Handwriting area for skin examination)

2.3. Mouth and Teeth

(Handwriting area for mouth and teeth examination)

2.4. Respiratory System (Also indicate any previous history of TB)

2.5. Cardiovascular System

2.6. Gastro-intestinal Tract

2.7. Genitourinary

2.8. Muscular- Skeletal (Especially deformities)

2.9. Gait

2.9. Central Nervous System

2.10. Behavioural problems

3. DIAGNOSIS / ASSESSMENT

- Neuro -Cerebral
- C.V.A. – How long ago?
- Previous Neuro surgery YES NO
- V.P. Shunt YES NO
- Aggression YES NO
- Depression YES NO
- Epilepsy YES NO
- Other (please specify) _____

4. Present Treatment and Related information:

5. Information recommendation on continued care at receiving NGO:

6. Feeding:

Normal diet: YES NO

Special Diet: YES NO

Teeth: YES NO

Dentures: YES NO

Tube Feeding:

Reason for Tube Feeding?

Is the tube fed permanent YES NO

- | | | | |
|-------|-------------------------------|-----|----|
| i. | Naso – gastric feeding | YES | NO |
| ii. | Gastro intestinal tube | YES | NO |
| iii. | Constipation | YES | NO |
| iv. | Colostomy | YES | NO |
| v. | Incontinent | YES | NO |
| vi. | Catheter | YES | NO |
| vii. | Allergies | YES | NO |
| viii. | Diabetic | YES | NO |

6.1. Allergies

YES or NO

If yes please specify

6.2. Drug/ alcohol addiction

YES or NO

If yes please specify the number of years of Drug or Alcohol abuse or substance abuse:

Details of GP/ Medical Practitioner:**Designation:****Name:****Signature:****Date:**
