NHS Continuing Health Care Questionnaire

1. Full Name of Patient: MR/MRS/MISS …………………………………………………………………

2. Patient's Date of Birth ………………… Is the patient Living or deceased?………………………..

	Yes	No
3. Has the Patient ever been detained under Section 3 of the Mental Health Act 1983? (If it is relevant, how long ago this occurred?)		

4. Please state the Patient's past and current medical history and physical illnesses in particular whether the Patient has suffered from Diabetes, Epilepsy, Parkinson's Disease, Cancer, Arthritis, Stroke etc (please give dates where possible of diagnosis):

   ………………………………………………………………………………………………………..…

   ……………………………………………………………………………………………………….

5. Does/Did the Patient have any allergies:

   ……………………………………………………………………………………………………...…

	Yes	No
6. Does/Did the Patient smoke or has the Patient ever smoked?		

7. Did/Is the Patient attended at the Care Home by a specialist nurse (for example Parkinson, Epilepsy, Diabetic, Community Psychiatric or Continence nurse), a Dietician; Consultant or other healthcare professional from outside of the Home?

   ………………………………………………………………………………………………………...

8. How often are/were the visits by the above professional (e.g. daily, weekly, fortnightly, monthly etc)

   ………………………………………………………………………………………………………

Care Home Details:

9. Address of Current/past Care Home

   ………………………………………………………………………………………………………

10. On what date did the Patient become a resident of the above Care Home?

    …………………………………(Month & Year)

11. Could you please give an estimate of how much has been paid to date to the Care Home/s to provide for the care of the Patient? £_____________

12. How much if any, has been paid by a deferred payment?______________

13. Please indicate whether the Care Home is one of the following:

	Yes	No
a **residential** home?		
a **nursing** home?		
a **residential** home for the elderly mentally infirm?		
a **nursing** home for the registered elderly mentally infirm?		

Please tick more than one if appropriate

If the Care Home is a dual registered home, please let us know if the Patient has/had a residential or nursing bed?...

It is very important that we know the answer to this question, if you are unsure please telephone the Care Home where the Patient is or was to find out the answer.

14. Care Needs

We need to know whether the Patient needs or needed assistance and supervision on a daily basis to help with personal care and hygiene. Please can you answer the following questions ticking one or more of the boxes, if appropriate?

Personal Care

		Yes	No
(i)	Washing and bathing		
(ii)	Brushing teeth or dentures		
(iii)	Assistance or supervision with dressing/undressing		
(iv)	Hair care, washing, brushing or combing		

(v) Nail care

Eating and Drinking

		Yes	No
(i)	Does or did the Patient need any assistance eating or drinking?		
(ii)	If food is cut up in advance can the Patient then eat independently?		
(iii)	Does the Patient regularly eat without supervision, reminding, coaching or encouragement?		
(iv)	Does the Patient need someone to help with feeding?		
(v)	If help is/was required, is that due to breathing or swallowing difficulties?		
(vi)	Was/Is the Patient fed intravenously i.e. via a tube?		
(vii)	Was/Is the Patient on any special diet?		
(viii)	Was/Is the Patient regularly assessed by a dietician?		

Mobility

		Yes	No
(i)	Could/Can the Patient walk without any supervision or assistance?		
(ii)	If No, does/did the Patient need a walking aid? Please detail the type of walking aid used i.e. walking stick/s, Zimmer frame with or without wheels or tripod………………………………. ………………………………………………………………………………………………………..		
(iii)	Is/was assistance still required when using the walking aid?		
(iv)	Does/did the Patient require any assistance getting in or out of bed?		
(v)	If so, does/did the Patient use a hoist?		

(vi) Is/was the Patient wheelchair bound or chair bound?

(vii) Was/Is the Patient registered disabled?

(viii) Did/Does the Patient need to be turned or re-positioned regularly to prevent pressure areas and wounds developing?

(ix) Did/Has the Patient's mobility deteriorated since becoming a resident of the Care Home?

Toileting

The section below refers to any help or assistance the Patient requires for his/her toileting needs.

	Yes	No
(i) Was/ Is the Patient incontinent?		
(ii) Did/Does the Patient require any assistance with toileting?		
(iii) Was/Is the Patient urinary incontinent only?		
(iv) Or doubly incontinent?		
(v) Did/Does the Patient have a urinary catheter or sheath?		
(vi) Did/Does the Patient require frequent attention with the changing of incontinence pads?		
(vii) Or for catheter care?		
(viii) Did/Does the Patient need frequent attention for colostomy/ Ileostomy care?		
(ix) Did/Does the Patient have problems with constipation?		

Did/Has their continence status deteriorated since becoming a resident in the Care Home?…………………………………………………………………………………………………

Communication

This section refers to the Patient's level of communication.

Yes No

(i) Could/Can the Patient communicate verbally?

(ii) If no, did/does the Patient have difficulty communicating due to confusion or memory loss?

a. Speech impairment
b. Loss of speech

(iii) Could/Can the Patient express their needs by non verbal communication?

a. Pointing
b. Writing
c. Blinking

(iv) Could/Can the Patient communicate when in pain?

a. Or when suffering any other type of distress?

(v) Did/Does the Patient have sight impairment for example:

a. Total/partial blindness
b. Glaucoma
c. Cataracts

(vi) Did/Does the Patient have a hearing impairment?

(vii) If so, did/does the Patient require a hearing aid?

Medication

This section relates to any prescribed medication taken by the Patient, please provide as much detail as possible.

Yes No

(i) Did/Does the Patient take prescribed medication?

(ii) Could/Can the Patient take the medication independently?

(iii) Did/Does the Patient require prompting, assistance and/or supervision to take medication?

(iv) Did/Does the Patient require medication to be administered to them?

(v) Is the medication administered:

a. By mouth
b. By injection
c. By any other method i.e. vaginally or rectally

(vi) Did/Does the Patient require medication creams to be applied to their skins?

(vii) Did/Does the Patient require his blood sugar/glucose levels monitored?

(viii) Did/ Does the Patient require a nebuliser?

(ix) Did/Does the Patient use an oxygen mask?

(x) Did/Does the Patient require pain management care?

Please tell us how any pain relief is administered.

……………………………………………………………………………………………………..

Do you know if/was any medical equipment is needed to help care for the Patient?

……………………………………………………………………………………………………..

Was the Patient able to self medicate before going into the Care Home? Y/N

If not, who did this for the Patient? ……………………………….

Psychological Wellbeing and Behaviour

Yes No

(i) Did/Does the Patient suffer with any mental health problems, for example

a. Depression
b. Anxiety
c. Other, give details ………………………………………………………………………

(ii) Did/Does the Patient suffer from dementia, for example

a. Alzheimer's disease
b. Multi infract dementia
c. Other, give details ………………………………………………………………………………

(iii) Has the Patient ever received care and/or treatment from their local mental health services? (past or present)
If yes, please give details ………………………………………………….
…………………………………………………………………………………………………..

(iv) Did/Is the Patient confused and/or unaware of their surroundings?

(v) Idid/s the Patient disorientated to time and place?

(vi) Did/Can the Patient recall friends/relatives and everyday activities?

(vii) Did/Does the Patient repeat themselves often or lose train of thought?

(viii) Did/Does the Patient forget recent events?

(ix) Did/Does the Patient demonstrate any difficult behaviour?
For example:
a. Verbally or physically aggressive?
b. Display noisiness and restlessness?

(x) Did/Does the Patient wander and/or try to abscond?

(xi) Did/Does the Patient become easily upset?
(xii) did/Does the Patient display disinhibited behaviour for example:
a. Use of bad language
b. Taking their clothes off inappropriately
c. Making unwanted advances to others

(xiii) Does the Patient inappropriately urinate or defecate?

(xiv) Does the Patient refuse care for example
a. Refuse to eat or drink
b. Refuse help with personal hygiene

(xv) Did/Does the Patient display passive or unresponsive behaviour?

(xvi) Did/Is the Patients behaviour unpredictable and/or repetitive?

(xvii) Did/Does the Patient display any other behaviour patterns?
If so give details ……………………………………………………………………………………
……………………………………………………………………………………………………….
Did/Does the Patient pose a potential risk to themselves and/or others that requires supervision and or monitoring?

(xviii) Please provide any other information that you think may be relevant regarding the Patients health and nursing needs…………………………………………………………………
……
What was Patients behaviour like **prior** to transfer into care home?
……..
……..

15. Have you or anyone else contacted the NHS/Primary Care Trust or Strategic Health Authority about funding the Patients care? Yes No

Please note: In England the local health authority, is your local Primary Care Trust and/or the Strategic Health Authority, and in Wales it is the Local Health Board.

Please provide as much detail as you can, if you have answered YES to question 14, including:

(i) The date you first contacted the health authority ………………………………………………….

(ii) The date you received a response from the health authority ……………………………………….

(iii) Please give details of the response you received to your request for NHS funding
………..

Yes No

16. Is the person completing this questionnaire the Patient?

If YES, go to page 11 and sign the Form

If NO, continue and provide us with your contact details:

17. Your Full Name; MR/MRS/MISS ………………………………………………………………..

18. Your Full Address ……………………………………………………………………………
    ……………………………………………………………………………………………………
    ……………………………………………………………………………………………………
19. Home Telephone number ………………………………………………………………….

20. Work Telephone ……………………………………………………………………………

21. Your Date of Birth ………………………………………………………………………….

22. Your National Insurance Number ………………………………………………………….
23. Your e-mail address:
    ……………………………………………………………………………………….

    What times and how would you like to be contacted?
    a) Daytime ……………………………………………………………………………….….
    b) Evening ………………………………………………………………………………..……
    c) Other ……………………………………………………………………………………..

24. Please give details of your relationship to the Patient?
    ……………………………………………………………………………………………………..
    ……………………………………………………………………………………………………..

25. If the Patient cannot complete the Questionnaire themselves please give details as to why.
    ……………………………………………………………………………………………………
    …………………………………………………………………………………………………….
    ……………………………………………………………………………………………………..
    ……………………………………………………………………………………………………..

Please complete the enclosed Form of Authority and return to us with the completed questionnaire if the Patient wants you to act on their behalf. Without this we will only be able to correspond with the Patient.

	Yes	No
26. Form of Authority enclosed		

If the Patient is unable to manage their own affairs, and you are acting on behalf of the Patient you need to hold an Enduring Power of Attorney, or Lasting Power of Attorney, or have been appointed as a Receiver by the Court of Protection?

If any of these apply, **please provide a copy of the Enduring Power of Attorney/ Lasting Power of Attorney or written confirmation of your appointment as Receiver**.

	Yes	No
Copy of Enduring Power of Attorney enclosed		
Copy of Lasting Power of Attorney enclosed		
Copy of letter of appointment as a Receiver enclosed		

If you do not hold an Enduring Power of Attorney or Lasting Power of Attorney or have not been appointed as a Receiver by the Court of Protection, please tell us about your relationship to the Patient and why you are dealing with this on their behalf.

………
………
………

27. Care Plan

Please enclose a copy of the Care Plan if available to you (you can ask for this from the Care Home).

	Yes	No
Care Plan enclosed		

carehomeclaims

28. DECLARATION

I DECLARE THAT THE INFORMATION I HAVE GIVEN IN ANSWER TO ALL THE QUESTIONS IN THIS QUESTIONNAIRE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed:

……..

Dated:

…….

Please now return this completed questionnaire to:

Care Home Claims
4 Chestnut Avenue
Wetherby
LS22 6SG

If you have any queries, please contact us on: 0844 474 3208