Reservation Form

MS Care Centre

MS Care Centre Reservation form

Please ensure that all forms are completed in full:

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Reservation Form A My Personal Portrait and Healthcare information	**1-7**
Reservation Form B Requirements for my Respite Stay	**8-10**
Reservation Form C To be completed and signed by your GP	**11-13**

Incompleted forms cannot be processed

Completed forms should be returned by post to:
MS Care Centre
65 Bushy Park Road,
Rathgar, Dublin 6

Or

Email: mscare@ms-society.ie
Tel queries: 01 490 6234

Reservation Form A

My Personal Portrait and Healthcare information

I _____ consent to the MS Care Centre using the information provided in this reservation form to prepare my personal care plan for my respite stay.

Signed by Resident: _____

Signed by Resident representative in good faith: _____

Relationship to Resident: _____

State reason if signed by anyone on behalf of the resident applying for respite:

_____

_____

SECTION A MY PERSONAL PORTRAIT AND HEALTHCARE INFORMATION

PERSONAL DETAILS

Name: _____ I like to be called:_____ Date of Birth: _____

Male ☐ Female ☐ Marital status:_____ Occupation:_____

Address:_____

_____

My Email address: _____

My telephone number: _____ Mobile:_____

Allergies:	**No**	**Yes**	**Details**
Treatment:			

Reservation form A contd/….

MS Medical History: Date of MS Diagnosis:_____

Type of MS:_____

Other Medical Diagnosis:_____
Current or previous Medical/Surgical/Cardiac /Mental health history and treatment of same.

(a) **Medical Insurance Details**

	Yes	No	
Private Health Insurance			Name of scheme: Policy Number Expiry Date
Medical Card			Number: Expiry Date
Long Term Illness Card			Number: Expiry Date

(b) **My Personal Contacts**

	Name	Relationship	Telephone/Mobile
Next of kin			
Address (if different from above)			
	Name	Relationship	Telephone/Mobile
Principal Carer			

24 hour emergency contact during my respite stay			
	Name	Relationship	Telephone/Mobile
1st contact			Day Night
2nd contact			Day Night

(c) **My living arrangements**

Living alone		Spouse/partner		Relative/carer		Assisted accommodation	

Type of accommodation(e.g. ground floor/upstairs)
Accessibility:
Adaptations: (e.g. bathroom, lift, bed)
Assistive devices/technologies:
Type of bed required:
Any other relevant information:

(d) **Community Care Package**

Number of days per week		Number of hours per day	

PA Carer		Home Help		Shopping		Day Centre		MS therapy Centre	
								Alternative Therapies	
Comment:									

(e) **My healthcare professional contacts:** Please state **YES** or **NO** if you consent to the MSCC contacting the following healthcare professionals to support preparation of your careplan

	Yes/No	Name	Contact phone number(s)
General Practitioner GP GMS Reg Number			
Public Health Nurse			
Physiotherapist			
Occupational Therapist			
MS Ireland Regional Community Worker			

My hospital consultant record		
Consultant	Hospital attended	Hospital department attended
		1
		2

My anxieties and fears

My Hobbies and Interests

What I want to achieve from my respite stay: (eg: a good rest, an assessment with the MS Nurse / Physiotherapist)

My likes (eg: foods, activities, breakfast in bed)	**My dislikes** (eg: rising early, television,)
My preferences/ preferred routines: (eg: going to bed late and resting in bed in the afternoon)	
My social needs: (eg: I need someone to push my wheelchair if I am going outdoors)	

Signature of Resident :_____ Date Completed: _____

and/or Signature of Resident representative in good faith:_____

State reason if signed by anyone on behalf of the resident applying for respite:

_____

_____

Reservation Form B Requirements for my Respite Stay

Is this your first respite stay at MSCC? Yes ☐ No☐ How did you hear about the MSCC?

_____

Preferred reservation dates this year

	1st Choice	2nd Choice
First respite stay		
Second respite stay		

Planning for your stay and care needs at the MSCC

Dietary Needs	**Yes**	**No**	Please provide details if applicable
Do you have any food allergies?			
Do you require a special diet?			Eg Diabetic diet, coeliac/gluten free,
Do you need assistance with meals?			If yes, do you require: a) your food to be chopped Y/N, b) special cutlery Y/N, c) assistance with eating and/or drinking Y/N
Do you have a swallowing difficulty?			If yes, do you have a swallow plan or a SALT report Y / N **Please bring your swallow plan or SALT report with you.**
			Do you require a modified consistency diet Y/N. if yes, provide details of consistency required Soft☐, pureed ☐, liquidised ☐
Have you ever had any choking episodes?			

Sensory Need Support	**Yes**	**A little**	**No**	If yes/a little, please provide details of any support you require during your respite stay.
Do you have difficulty with your speech?				
Do you have difficulty with your hearing?				
Do you have difficulty with your vision?				

Reservation form B contd/….

Mobility Needs	Yes	No	Please provide details where necessary
Can you walk unaided?			
Do you use a mobility aid?			
Can you transfer to the toilet on your own?			If no, what assistance do you require(eg hoist, assistance X 1 person, 2 people)
Can you transfer to the bed on your own?			
Did you have any falls in the last 3 months?			If yes, please give details

We ask you to ensure that all personal equipment you bring into the MS Care Centre is clean and in perfect working order

Wound Care	**Yes**	**No**	**Please provide details where necessary**
Do you have a skin break/pressure sore/ wound being dressed?			
Please bring dressing packs and cleansing solutions, plus the specialist dressings and a letter from your public health nurse if you require dressings to be applied during your stay.			

Skin Care	**Yes**	**No**	**Please provide details where necessary**
Do you require a specialised air mattress?			If yes, what type?
Do you have a cushion for chair			If yes, please have it serviced prior to admission/bring pump
Please provide the following details: Your current weight: Your height:			

Elimination	**Yes**	**No**	**Please provide details where necessary**
Bladder management Do you have a urinary catheter in situ?			If yes, please bring one night bag per night for the duration of your respite stay, a spare catheter and instillagel if you have a supra pubic catheter
Do you require assistance with Self Intermittent Catheterisation?			

Elimination continued			
Bowel Management	**Yes**	**No**	**Please provide details where necessary**
Do you require assistance with elimination/removal of faeces?			
Do you use continence products?			**If yes, please bring a supply for the duration of your stay**

Medication Management	**Yes**	**No**	**Please provide details where necessary**						
Do you self- medicate?									
Do you require assistance with injections?			**Sun**	**Mon**	**Tue**	**Wed**	**Thurs**	**Fri**	**Sat**
Do you require assistance with suppositories?			**Sun**	**Mon**	**Tue**	**Wed**	**Thurs**	**Fri**	**Sat**
The MS Care Centre does not stock any medications and has a strict policy on the management of medication during your stay.									

If you require **ANY** assistance with your medications from our nurse during your stay, please complete the following to allow the MSCC pharmacist link with your pharmacist to plan safe medication management for the duration of your respite stay:

Pharmacy Name: _____

Telephone: _____ Fax:_____

Email:_____

Pharmacy address:_____

Resident Signature: _____ Date:_____

and/or Resident Representative in good faith : _____ Date:_____

State reason if signed by anyone on behalf of the resident applying for respite:

_____

_____

Reservation Form C (Pages 11, 12 & 13) For completion by your GP

Resident Name:

Address:

Medical Card Details: Number: Expiry Date:

ALLERGIES:
Treatment of allergies details:

Date of last visit to GP: _____ **Date of last visit to Neurologist :_____**

Neurological Diagnosis: **Date of Diagnosis:**

Medical Diagnosis:

Other Medical History: Current or previous Medical/Surgical/Cardiac /Mental health history and treatment of same.
Attached Electronic medical summary Yes ☐ No ☐

Any medical condition requiring specialist diet: eg IDDM, Coeliac, Renal,

Any history of swallowing difficulties? If yes please provide details

Active medical concerns: The MSCC has an open door policy and is unable to provide respite stay to anyone who is at risk of wandering from the building or who demonstrates aggressive/violent behaviours.

Is this patient at risk of wandering from the MSCC? Yes ☐ No ☐
Does this patient demonstrate aggressive/violent behaviour? Yes ☐ No ☐
Does this patient have dementia/Alzheimer Disease? Yes ☐ No ☐

Cognitive Status

Is this patient alert and orientated in time and place? Yes ☐ No ☐
Does this patient demonstrate poor short term memory? Yes ☐ No ☐
Does this patient demonstrate poor long term memory? Yes ☐ No ☐

PLEASE PROVIDE AN ELECTRONIC OR WRITTEN LIST OF CURRENT PRESCRIBED MEDICATIONS

Safe Management of Medications: Do you consider this patient safe to self medicate for the duration of their respite stay? **Yes/No.** If **No** please state reason:

Reservation form C contd/

Additional relevant information:

GP Details	**GP Stamp**
Name of GP (Block Capitals) Address:_____ _____ Phone No _____ Fax No. _____ GMS No: _____ Surgery opening hours Monday - Friday AM_____ PM_____	

GP Signature_____ **Date:_____**

Reservation form C contd/ **FOR COMPLETION BY GENERAL PRACTITIONER**

(1C) PREFERENCES AND WISHES IF YOUR PATIENT BECOMES SERIOUSLY ILL DURING THEIR RESPITE STAY AT THE MS CARE CENTRE

It is really important to us that we care for your patient in the way that he/she wants to be cared for at the MSCC. We want to ensure that any decisions about his/her treatment should he/she become seriously ill during their respite stay at the MS Care Centre, are based on their values, wishes and personal preferences.

Currently, it is our policy for staff to perform CPR and access immediate medical treatment and/or transfer residents for active treatment in an acute hospital if they become seriously ill.

This form concerns the preferences for resuscitation and life-prolonging treatment if your patient becomes seriously ill during their respite stay at the MS Care Centre. It is to be filled out by you with your patient and is for the attention of the MS clinical staff, paramedics and hospital staff in the case of an emergency.

KEY TREATMENT DECISIONS

I want staff to perform CPR and access immediate medical treatment and/or transfer me for acute treatment in a general hospital if I become seriously ill in order to prolong my life. ☐

I would like life-prolonging treatment, **only if** the treating doctor(s) consider that this life-prolonging treatment is appropriate for me. ☐

I do not want life prolonging treatment at all. If life prolonging treatment has started, I request that it is stopped ☐

IN ALL CASES, COMFORT TREATMENT WILL BE PROVIDED

I have discussed my own specific preferred wishes with my GP in the event that I become seriously ill during my respite stay ☐

THIS FORM MUST BE SIGNED BY BOTH PATIENT AND DOCTOR.

Signature of Patient: _____ Date:_____ and/or

Signature of patient representative signed in good faith, if patient is unable to sign.
Relationship to Patient: _____ Signature:_____ Date:_____

I declare that in my professional opinion, the above named individual has the capacity to understand the contents of this document, and that this person affirms that he or she is aware of the nature of the wishes expressed.

Doctors Signature:_____ Date:_____

My patient _____ **has additional preferred wishes** in regard to his/her management should he/she become seriously ill during their respite stay at the MSCC. I am enclosing the appropriate signed documentation outlining his/her preferred wishes. Documentation supplied Yes ☐ No ☐

My Patient _____**has not** discussed any specific preferred wishes with me. I **am not** enclosing any documentation to this regard. ☐

PCP 1c Preferred Wishes (this page to be inserted in section 1 of personal care plan)