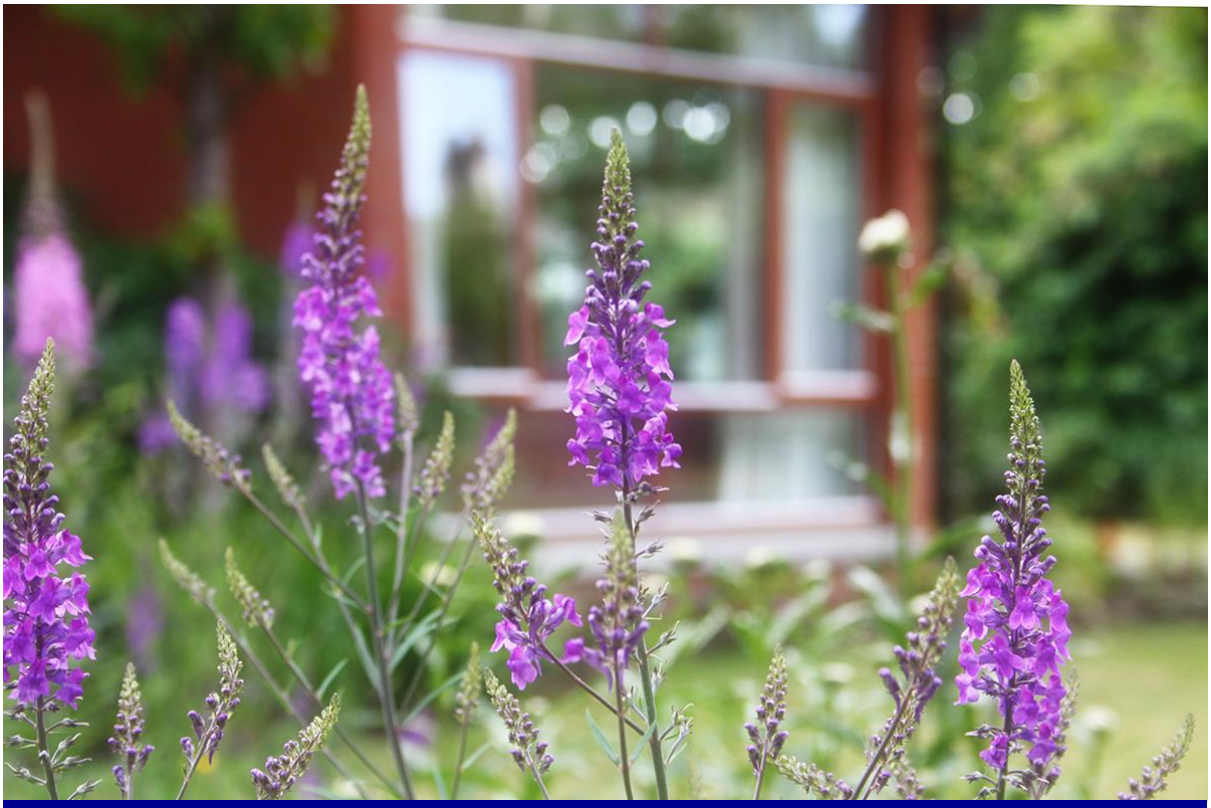

Reservation Form

MS Care Centre

MS Care Centre Reservation form

Please ensure that all sections are completed in full:

Incomplete forms cannot be processed

Completed forms should be returned by post to:
MS Care Centre
65 Bushy Park Road,
Rathgar, Dublin 6
Eir Code: D06 CV90

Or

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

For office Use Only **This form will be sufficient for 14 months**

REFRENCE NO: _____

DATE RECEIVED: _____

Section A

My Personal Portrait and Healthcare information

I, First Name: _____Surname:_____
Consent to the MS Care Centre creating and maintaining a file for me.
Other consent obtained if required:
Please state if you consent to the MSCC contacting your GP and the healthcare professionals you have listed on page 7, to include pharmacist if applicable, in order to support preparation of your careplan. Yes ☐ No☐

MS Ireland complies with the Irish Data Protection Acts, 1988 to 2018, and the General Data Protection Regulation or GDPR (Data Protection Legilsation) in respect of all personal data it handles.

Signature: _____

Signed by Resident representative in good faith: _____

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

Relationship to Resident: _____

We are aware that some residents may be provided with 1:1 or 2:1 care at home. Please note, here at the M.S. Care Centre we aim to provide a high standard of care to all our residents as part of a group of 12.

Is this your first respite stay at MSCC? Yes ☐ No ☐

Have you been referred by: MS Regional worker ☐ Public Health Nurse ☐ GP ☐ Hospital Staff ☐ Myself ☐ Other _____

In order to accommodate the demand for respite we aim to facilitate everybody where possible with 2 weeks respite per year according to individual care needs. This includes group bookings. If you are requesting specific dates which are unavailable we apologies in advance and we are happy to consider alternative dates where possible.

Are you booking as part of a group? If yes, Group leader Name: _____

Preferred reservation dates this year

	1st Choice	Group booking?	2nd Choice	Group booking?
First respite stay				
Second respite stay				

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

MY PERSONAL PORTRAIT AND HEALTHCARE INFORMATION

PERSONAL DETAILS

NAME (As stated on passport/medical card/public services card)

First Name: _____ Surname: _____

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

Male ☐ Female ☐ Marital status: _____ Occupation: _____

Address: _____

_____

My Email address: _____

My telephone number: _____ Mobile: _____

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

HEALTHCARE INFORMATION

Neurological Medical History: _____

Date of Neurological Diagnosis: _____

If diagnosis is MS, Type of MS: _____

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

Allergies:	**No** ☐ **Yes** ☐ If Yes, Please provide details below

Type of allergy: Drug ☐ Food ☐ Other(e.g.; Shampoo, surgical tape) ☐

Name of Allergen: _____

_____

Reaction to same: _____

Treatment: _____

History of anaphylaxis: No ☐ Yes ☐ If Yes, do you carry a pen?

Medication Management	**Yes**	**No**	**Please provide details where necessary**						
Do you self- medicate?			Please provide list of medication						
Do you require the assistance of our nurses to assist you with your medication?			If yes, please provide list of medication and enter pharmacy details below.						
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**

Pharmacy Name: _____

Pharmacy address:_____

Telephone: _____ Fax:_____

Email:_____

My healthcare professional contacts:

	Name	Contact phone number(s)
General Practitioner. GP GMS Number:		
Public Health Nurse		
Physiotherapist		
Occupational Therapist		
MS Ireland Regional Community Worker		
Speech and Language Therapist		

My hospital consultant record		
Consultant	Hospital department attended	Hospital

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:									

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:							

Section B

Help us plan for your respite stay at the MS Care Centre

Sensory Need Support	**Yes**	**No**	**If yes please state 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?			

My anxieties and fears are:	**My Hobbies and Interests are:**
What I would like from my respite stay: (e.g. a good rest, an assessment with the MS Nurse / Physiotherapist)	

What I like (e.g. foods, activities, breakfast in bed)	**What I dislike** (e.g. rising early, television,)
My personal preferences and preferred routines: (e.g. going to bed late and resting in bed in the afternoon)	
My social needs are: (e.g. I need someone to push my wheelchair if I am going outdoors)	

Mobility/transfer Needs	Yes	No	Please provide details where necessary
Did you have any falls in the last 3 months?			If yes, please give details
Do you have a home exercise programme prescribed by a physiotherapist			If yes, please provide copy of same.
Can you walk unaided?			If no, please tick aids used for mobilising: Crutch ☐ Walking stick ☐ Rollator ☐ Manual wheelchair ☐ Powered Wheelchair ☐ Scooter ☐ Any other comment:
Can you transfer unaided?			If no, please tick aids used for transfers: Bed Lever ☐ Banana Board ☐ Over bed pole ☐ Assistance x 1 staff ☐ Assistance x 2 staff ☐ Standing turner ☐ Sit to stand hoist ☐ Full Hoist ☐ Sling type: _____ Any other comment:
Can you transfer to the toilet unaided?			
Can you transfer to the bed unaided?			
Can you shower unaided?			If no, complete below: Shower chair required Yes ☐ No ☐ Type: Free standing ☐ Self propelled ☐ Tilt ☐ Assistance of staff required ☐

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

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:			

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.			

Dietary Needs	**Yes**	**No**	Please provide details if applicable
Do you require a special diet?			E.g. Diabetic diet, coeliac/gluten free
Do you need assistance with meals?			If yes, please tick: Special cutlery ☐ Special cup ☐ Food chopped ☐ Assistance of staff with your meal ☐ Assistance of staff with your drinks ☐
Have you ever had any choking episodes?			
Do you have a swallowing difficulty?			If yes, do you have a swallow plan or a SALT report Yes☐ No☐ **Please bring your swallow plan or SALT report with you.**
Do you require a modified consistency diet			If yes, provide details of consistency required: Soft ☐ Mince/Moist☐ Pureed ☐ liquidised ☐ Chopped ☐ State size:_____

Elimination- Bladder	**Yes**	**No**	**Please provide details where necessary**
Independent			If no, Please complete below
Continence wear			If yes, please bring a supply for the duration of your stay. Assistance of staff Yes ☐ No ☐
Self Intermittent Catheterisation			Assistance of nurse required Yes ☐ No ☐
Urinary Catheter In situ			If yes, please bring one night bag per night for the duration of your stay, a spare catheter, and if you have a supra pubic catheter please bring instillagel
Do you use a washout?			If yes, please bring sufficient supply for the duration of your stay with extra leg bags.

Elimination-Bowel	**Yes**	**No**	
Independent			
Continence wear			If yes, please bring a supply for the duration of your stay .Assistance of staff Yes ☐ No ☐
Other assistance required.			If yes, state details

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:

_____

_____

Section C (Pages13, 14, 15) 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: e.g. Diabetes, Coeliac, Renal,

Any history of swallowing difficulties? If yes please provide details

Resident safety at the MSCC. 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 ☐

Safe Management of Medications

Please Provide an Electronic or written list of current prescribed medications as required by our approving Doctor.

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

Section form C cont…. **FOR COMPLETION BY GENERAL PRACTITIONER**

Additional relevant information or current medical concerns	
GP Details	**GP Stamp**
Name of GP (Block Capitals) _____ **Address**:_____ _____ **Phone No**:_____ **Healthmail Address**: _____ **Fax No:** _____ **GMS No:** _____ Surgery opening hours Monday - Friday AM_____ PM_____	
GP Signature_____ **Date:_____**	

Section Form C cont….**FOR COMPLETION BY GENERAL PRACTIONER**

PREFERENCES AND WISHES IF YOUR PATIENT BECOMES SERIOUSLY ILL DURING THEIR STAY AT THE MS CARE CENTRE.

Section A
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.

Please complete Section B if your patient has other preferred wishes:
Section B
My patient _____ does not wish to have CPR performed and I am enclosing supporting documentation confirming their wishes.

I declare that in my professional opinion, the above named individual has the capacity to understand the contents of this enclosed documentation.

Doctors Signature: _____ Date: _____

GP STAMP

PCP 1 preferred wishes (This page to be inserted on section 1 of personal care plan)