APPLICATION / ASSESSMENT FOR LONG TERM CARE CARE PLAN

APPLICANT'S NAME	(SURNAME)	GIVE	N NAMES)	M.H. REGISTRATION NO.
DATE ASSESSED	LOCATION WHEN ASSESSED			
FUNCTIONAL ASSESSMENT				
SIGHT	GLASSES	DATE TESTED	BY WHOM	
HEARING	AID	DATE TESTED	BY WHOM	
SPEECH				
TEETH - DENTURES: UPPER [LOWER ARE THEY	WORN? YES NO		
DENTIST		DATE EX	AMINED	
MOBILITY AIDS:				
ALLERGIES/SENSITIVITIES:				
DIET CONTROLLED FOR:	WEIGHT REDUCTION	FOR DIABETES	FOR SODIUM	
GIVE DETAILS:				
CARE PLAN (Including Medication	ons and Treatments)			
FACTORS AFFECTING SAFE C	CARE (e.g. Attitude, Behaviours, Use	of Alcohol, Drugs, Wanderin	g)	
				*