Private & Confidential

Care Support Details

To help us to fully meet the needs of our guests, please complete ALL relevant sections in BLACK INK, BLOCK CAPITALS and tick appropriate boxes.

We ask that the form is completed either by the guest themselves or someone who is familiar with the guest's needs.

If you are completing this form on behalf of the guest please provide your contact details in the spaces provided on the back page

GUEST'S PERSONAL DETAILS

Date of Visit:_____ **Reservation Number:**_____

Surname:_____ **First Name:**_____

Name by which the guest prefers to be known:_____

Date of Birth: _____

Home Address: _____

_____

County:_____ **Postcode:**_____

Telephone (inc area code):_____ **Mobile:**_____

E-mail:_____

To help meet the guest's needs, please give details of ethnic, cultural and linguistic background. Also details of religious beliefs (please add additional pages if needed).

Ethnic Origin:_____**Religion:**_____

CONTACTS - Next of Kin

Name:_____
Address:_____
County:_____**Postcode:**_____
Tel (inc area code):_____ **Email:** _____

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CONTACTS - Emergency Contact

Name:_____

Tel (inc area code):_____

Relationship to guest:_____

Address:_____

County:_____ Postcode:_____

Email:_____

CONTACTS - Doctor

Name of GP:_____

Tel (inc area code):_____

Name of Surgery:_____

Address:_____

County:_____ Postcode:_____

Nature of Disability

Please give a brief description of the guest's disability

MCA & DOLs

Has a Mental Capacity assessment been completed? Y ☐ N ☐
If yes, please enclose a copy

Is the guest able to give their own permission for medical treatment? Y ☐ N ☐
If not, please enclose the protocol

Does the guest have a Deprivation of Liberty Order? Y ☐ N ☐

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This form must be completed and returned to us no less then four weeks before the start of the holiday

Medical Details

Does the guest have or require treatment for any of the following conditions?

Asthma Attacks. Y ☐ N ☐

How often do attacks occur?_____

Describe a 'typical' attack._____

_____

Action Required._____

_____

Allergies Y ☐ N ☐

Cause(s) of allergy_____

_____

Symptoms_____

_____

Action Required_____

_____

Heart Condition Y ☐ N ☐

Give details of any special consideration or action required

_____

_____

_____

Diabetes Y ☐ N ☐

If yes, we will send a separate form for you to complete

Epilepsy Y ☐ N ☐

If yes, we will send a separate for m for you to complete

Please use this space to tell us of any other medical details which you feel we should know.

Medication

Is the guest taking any medication? Y ☐ N ☐

If yes, please give details on reverse.

Medication Programme

Guest Name	

Please selecbne:

- ☐ Guestis not taking any regular medication
- ☐ Guest is able td ook after own medication
- ☐ Guest would likeTrevanion House tolook after medication and help them with taking it.

Medication	Quanity Sent	Breakfast (8.00-9.00)	Lunch (12.30-13.30)	Evening Meal (6:00 - 6:30)	Bedtime
A					
B					
C					
D					
E					
F					
G					
H					
I					
J					

Note: Please Indicate any special conditions that apply to any particular medication(such as before or after food)or if the timing of any dose is especially important. The indicated times minimise thedisruption to our normal programme of activities.

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Personal Profile of Care Needs

MOBILITY

Walks without assistance Y ☐ N ☐
Can walk long distances (further than 0.5 miles) Y ☐ N ☐
Can climb stairs unaided Y ☐ N ☐
Needs the use of wheelchair for distances Y ☐ N ☐
Approximately how far can the guest walk?_____
Other comments:_____
_____

BATHING

Prefers to wash during AM ☐ PM ☐
Showers unaided Y ☐ N ☐
Bathes unaided Y ☐ N ☐
Should be attended whilst bathing/showering Y ☐ N ☐
Needs help washing body Y ☐ N ☐
Needs help washing hair Y ☐ N ☐
Needs helps shaving Y ☐ N ☐
Needs help teeth cleaning Y ☐ N ☐
Other comments:_____
_____

DRESSING

Dresses unaided Y ☐ N ☐
Undresses unaided Y ☐ N ☐
Needs supervision Y ☐ N ☐
Needs help choosing appropriate clothes Y ☐ N ☐
Other comments:_____
_____

SLEEP/ NIGHT CARE

Gets in and out of bed unaided Y ☐ N ☐
Needs assistance to toilet at night Y ☐ N ☐
Wanders at night Y ☐ N ☐
Other comments:_____
_____

TOILETING

Incontinent of urine Y ☐ N ☐
Incontinent of faeces Y ☐ N ☐
Wears incontinence pads day/night Y ☐ N ☐
Needs assistance with monthly periods Y ☐ N ☐
Needs support with catheter Y ☐ N ☐
Needs support with stoma Y ☐ N ☐
Other comments:_____
_____

SIGHT

Does the guest have sight problems? Y ☐ N ☐
Please give details(ie wears glasses for r eading):_____
_____

HEARING

Does the guest have hearing problems? Y ☐ N ☐
Please give details (ie wears hearing aids):_____
_____

NB In this context, 'personal care' means giving assistance beyond advice and encouragement with personal hygiene

Care Support Details

Personal Profile of Care Needs

COMMUNICATION

What is the guest's preferred method of communication?

VERBAL ☐

MAKATON ☐

PECS ☐

WRITTEN WORD ☐

DIETARY NEEDS

Does the guest require support to cut up food? Y ☐ N ☐

Does the guest require support with eating? Y ☐ N ☐

Are dietary needs for medical reasons? Y ☐ N ☐

If yes, please attach details.

How is the guest's appetite? (Good/Poor/Tendancy to overeat)

Known Food Dislikes:

ALCOHOL

Can the guest drink alcohol? Y ☐ N ☐

(according to medical recommendations)

Please advise of any limitations:

SMOKING

Does the guest normally smoke? Y ☐ N ☐

If yes, is there a limit/restriction? Y ☐ N ☐

Please give details:

RISKS

Please list any risks/concerns, giving details. For example poor road safety, tendency to wander, poor sense of danger, (Please attach additional sheets/current risk assessments as necessary)

MONEY MANAGEMENT

Does the guest require support to manage their money while on holiday? Y ☐ N ☐

If so, would you like us to act as 'bank' for personal money? Y ☐ N ☐

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Personal Profile of Care Needs

Please list any other details, care or behavioural, which will help us ensure that we can meet the needs of the guest whilst on holiday?

Before you send...

Ensure that you have completed ALL relevant parts including details of the person completing this fom on the back page of this page in as much detail as possible.
Please feel free to enclose additional sheets as needed.
Ensure that you have, if necessary

- ☐ Enclosed a curent copy of the individual care plan
- ☐ Taken a copy of this completed form for your records

Data Protection

I understand and agee that Trevanion House Holidays Ltd is permitted to hold personal information about a guest as identified in this care support form as part of its Guest's Records and may use such information in the course of the guests

The guest agrees that by completing this form Trevanion House Holidays Ltd may disclose such information to third parties in the event that such a disclosure is, in the organisation's view, required for the proper conduct of the guest's care. This applies to the information held, used and disclosed in any medium.

Care Support Details

Details of Person Completing Form (if not guest)

Surname: _____ First Name:_____

Relationship to guest: _____

Correspondence Address: _____

_____

County: _____ Postcode: _____

Telephone (inc area code): _____

Mobile Number: _____

Email: _____

Signature of person completing form

Signed: _____

Date: _____

Please return form to...

Tracey Barrett - Registered Care Manager
Trevanion House Holidays Ltd
Trevanion Road
WADEBRIDGE
Cornwall
PL27 7PA

Alternatively you can complete this form online at www.trevanion.co.uk
Refer to booking information for your individual login details.

If you have any problems completing this form please call 01208 814903
or email: enquiry@trevanion.co.uk