NHS Continuing healthcare questionnaire

MOORE BLATCH

This questionnaire is designed to help us make a preliminary assessment, entirely free of charge and with no obligation, as to the merits of a claim for NHS Continuing Healthcare on behalf of the Applicant's estate. If we feel that there is evidence of a primary health need which would support an NHS continuing healthcare assessment, then we will, of course, advise you and you can make a decision at that stage whether or not you wish to instruct this firm to take matters forward on your behalf.

PART A

Personal details of person who received care ("the Applicant")

Title:	
Name:	
Home address: (immediately prior to care home)	
Date of Birth:	
Date of Death:	
Diagnosed medical conditions/illnesses:	
Name and address of general practitioner:	
Name and address of hospitals attended since being admitted into care:	
Name of address of social worker/care co-ordinator:	
Name and address of any other health professionals (e.g district nurses) involved in the Applicant's care:	
Name and address of Clinical Commissioning Group (formerly Primary Care Trust) if known:	

PART B
Details of care

Name and address of care home/care agency:	
Which of the following most accurately describes the place where the Applicant received care:	☐ Own home ☐ Residential home ☐ Nursing home ☐ Elderly Mentally Infirmed (EMI) Residential Home ☐ Elderly Mentally Infirmed (EMI) Nursing Home
Period of care:	From: to:
Amount of fees already paid by the Applicant for care: (please provide an estimate if this figure is not known)	£ total / monthly / weekly * *please delete as appropriate
Amount contributed by the local authority:	£ monthly / weekly * *please delete as appropriate
Was the Applicant in receipt of RNCC (Registered Nursing Care Contribution) from the Clinical Commissioning Group/NHS?	Yes / No *please delete as appropriate
Please provide details of residency in any previous care homes (including dates):	

PART C
The Applicant's care needs

1. BEHAVIOUR

Was the Applicant: • aggressive or violent; • unpredictable; • noisy or restless; • challenging to deal with; • inappropriate towards others or their possessions; • prone to wandering; • disinhibited; • passive/unresponsive;	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No *please delete as appropriate
Please describe the Applicant's behaviour:	

PART C

The Applicant's care needs

2. COGNITION

Was the Applicant:	
• able to recognise family members and/or friends;	Yes / No
• disorientated;	Yes / No
• muddled or confused;	Yes / No
• able to absorb information;	Yes / No
• able to assess risks;	Yes / No
• able to make decisions about key aspects of their life?	Yes / No
Did the Applicant:	
• suffer short term memory problems;	Yes / No
• suffer long term memory problems;	Yes / No
• tend to forget recent events;	Yes / No
• tend to concentrate on the past?	Yes / No
	*please delete as appropriate
Please describe the Applicant's cognition:	

3. PSYCHOLOGICAL / EMOTIONAL NEEDS

Did the Applicant:	
• suffer with mood swings;	Yes / No
• display anxious or distressed behaviour;	Yes / No
• suffer with depression;	Yes / No
• require any medication in relation to anxiety or depression;	Yes / No
• suffer with hallucinations or delusions;	Yes / No
• have difficulty sleeping?	Yes / No
Was the Applicant:	
• tearful and/or low in mood;	Yes / No
• agitated and irritable at times;	Yes / No
• at risk of suicide?	Yes / No
	*please delete as appropriate
Please describe the Applicant's psychological / emotional needs:	

4. COMMUNICATION

Was the Applicant:	
• able to reliably communicate with others;	Yes / No
• able to understand/absorb information;	Yes / No
• seen by a Speech and Language Therapist?	Yes / No
Did the Applicant:	
• require assistance to communicate;	Yes / No
• have a hearing or sight impairment;	Yes / No
• have a speech impairment;	Yes / No
• require non visual aids to communicate with others?	Yes / No
Did the Applicant's needs have to be anticipated because of their inability to communicate them?	Yes / No
	*please delete as appropriate

PART C
The Applicant's care needs

Please describe the Applicant's communication:	

5. MOBILITY

Was the Applicant:	
• independently mobile;	Yes / No
• able to weight bear;	Yes / No
• able to walk with assistance or supervision;	Yes / No
• able to mobilise with a walking aid (e.g frame, walking stick etc);	Yes / No
• at high risk of falls;	Yes / No
• wheelchair or chair bound?	Yes / No
Did the Applicant:	
• suffer with muscle weakness;	Yes / No
• have difficultly with coordination;	Yes / No
• require a hoist for transfers;	Yes / No
• require turning/repositioning;	Yes / No
• co-operate with transfers/repositioning?	Yes / No
	*please delete as appropriate
Please describe the Applicant's mobility:	

6. NUTRITION

Did the Applicant:	
• feed him/herself;	Yes / No
• require feeding by care staff;	Yes / No
• require feeding by artificial means (e.g PEG);	Yes / No
• require supplement feeding such as Ensure drinks;	Yes / No
• require a liquidised diet;	Yes / No
• experience swallowing difficulties;	Yes / No
• suffer with weight loss;	Yes / No
• suffer from dehydration/aspiration?	Yes / No
	*please delete as appropriate
Please describe the Applicant's nutrition needs:	

7. CONTINENCE

Was the Applicant:	
• incontinent of urine only;	Yes / No
• doubly incontinent?	Yes / No
Did the Applicant:	
• require the use of pads;	Yes / No
• require a catheter;	Yes / No
• suffer with frequent urinary tract infections;	Yes / No
• suffer with constipation?	Yes / No
	*please delete as appropriate
Please describe the Applicant's continence needs:	

PART C

The Applicant's care needs

8. SKIN INTEGRITY

Was the Applicant at risk of pressure damage?	Yes / No
Did the Applicant:	
• suffer from persistently broken/red/necrotic or blistered skin;	Yes / No
• suffer with pressure sores/ulcers;	Yes / No
• require treatment from a district nurse on a regular basis;	Yes / No
• require pressure relieving support surfaces such as beds, mattresses, overlays or cushions;	Yes / No
• require a specialist dressing regime;	Yes / No
• suffer with any skin conditions (e.g dermatitis, psoriasis, cellulitis, skin tears, skin rashes/infections?	Yes / No *please delete as appropriate
Please describe the Applicant's skin care needs:	

9. BREATHING

Did the Applicant:	
• suffer with any breathing difficulties;	Yes / No
• suffer with any lung conditions such as asthma, emphysema or pneumonia;	Yes / No
• regularly suffer from chest infections	Yes / No
• require a nebuliser/oxygen mask?	Yes / No *please delete as appropriate
Please describe the Applicant's breathing:	

10. DRUG THERAPIES, MEDICATION AND SYMPTOM CONTROL

Was medication administered to the Applicant:	
• themselves;	Yes / No
• by a registered nurse/carer?	Yes / No
Was the medication administered:	
• by mouth;	Yes / No
• by injection;	Yes / No
• by any other method?	Yes / No
Was the Applicant compliant with medications?	Yes / No
Did the Applicant require pain management care?	Yes / No *please delete as appropriate
Please list the Applicant's medications and the condition they treated (if known):	
Please describe the Applicant's pain management/symptom control:	

PART C
The Applicant's care needs

11. ALTERED STATES OF CONSCIOUSNESS

Did the Applicant suffer: • any strokes; • epilepsy; • blackouts/fainting episodes; • hypo/hyperglycaemic attacks?	 Yes / No Yes / No Yes / No Yes / No *please delete as appropriate
Please describe any episodes of unresponsiveness the Applicant may have had:	

12. OTHER SIGNIFICANT NEEDS

Please provide details of any care needs which have not been covered above:	

PART D
Your details (If you are not the Applicant)

Title:	
Name:	
Home address:	
Date of birth:	
Telephone number(s):	Home: Work: Mobile:
Email address:	
Relationship to Applicant:	
Do you have the following:	Grant of Probate Grant of Letters of Administration
Are you the sole Executor?	Yes / No *please delete as appropriate

PART D

Your details (If you are not the Applicant)

If not please provide contact details for the other Executor(s): (continue on another sheet if necessary)	Name: Address: Contact No: Name: Address: Contact No:

PART E

Your claim

Have you or the Applicant ever contacted the NHS/Clinical Commissioning Group regarding the possibility of NHS Continuing Healthcare?	Yes / No *please delete as appropriate
Was the Applicant ever assessed for NHS Continuing Healthcare? (this may be a checklist assessment or full assessment)	Yes / No *please delete as appropriate
If the answer to either of the above questions is yes, please provide details: (please also provide any copy documents when returning this form)	

I confirm that the information provided in this questionnaire is true to the best of my knowledge and belief.

Signed: _____ **Date:** _____

Please send for the attention of Mea North,
Moore Blatch LLP
Gateway House
Tollgate
Eastleigh
Hampshire
SO53 3TG

Please note that by completing this questionnaire, you will be providing us with personal data including sensitive data relating to your health. For further information about how we will use the personal data you provide to us, please read our Privacy Policy available on our website.

MOORE BLATCH

www.mooreblatch.com