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. 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 is receiving care ("the Applicant")

Title:	
Name:	
Home address: (immediately prior to care home)	
Date of Birth:	
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 current care home / care agency:	
Which of the following most accurately describes the place where the Applicant receives 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 * *delete as appropriate
Current amount being paid for care:	£ monthly / weekly * *delete as appropriate
Amount contributed by the local authority for care:	£ monthly / weekly * *delete as appropriate
Is the Applicant in receipt of RNCC (Registered Nursing Care Contribution) from the Clinical Commissioning Group / NHS?	Yes / No *delete as appropriate
Please provide details of residency in any previous care homes (including dates):	

PART C
The Applicant's care needs

1. BEHAVIOUR

Is the Applicant:	
• aggressive or violent;	Yes / No
• unpredictable;	Yes / No
• noisy or restless;	Yes / No
• challenging to deal with;	Yes / No
• inappropriate towards others or their possessions;	Yes / No
• prone to wandering;	Yes / No
• disinhibited;	Yes / No
• passive/unresponsive;	Yes / No
• resistive to care?	Yes / No
	*please delete as appropriate

PART C
The Applicant's care needs

Please describe the Applicant's behaviour:	

2. COGNITION

Is 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
Does 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

Does 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
Is 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

Please describe the Applicant's psychological / emotional needs:	

4. COMMUNICATION

Is 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

PART C

The Applicant's care needs

Does the Applicant: • require assistance to communicate; • have a hearing or sight impairment; • have a speech impairment; • need non visual aids to communicate with others?	 Yes / No Yes / No Yes / No Yes / No
Do the Applicant's needs have to be anticipated because of their inability to communicate them?	Yes / No *please delete as appropriate
Please describe the Applicant's communication:	

5. MOBILITY

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

6. NUTRITION

Does the Applicant: • feed him/herself; • require feeding by care staff; • require feeding by artificial means (e.g PEG); • require supplement feeding such as Ensure drinks; • require a liquidised diet; • experience swallowing difficulties; • suffer with weight loss; • suffer from dehydration / aspiration?	 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 nutrition needs:	

PART C

The Applicant's care needs

7. CONTINENCE

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

8. SKIN INTEGRITY

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

9. BREATHING

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

PART C

The Applicant's care needs

10. DRUG THERAPIES, MEDICATION AND SYMPTOM CONTROL

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

11. ALTERED STATES OF CONSCIOUSNESS

Does 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:	
Does the Applicant have capacity to manage their own affairs?	Yes / No *please delete as appropriate
If no, do you have any of the following:	☐ Registered Enduring Power of Attorney ☐ Registered Lasting Power of Attorney ☐ Deputy Order

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
Has the Applicant ever been 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

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