Badisa Huis Wittekruin

"We serve with compassion"

URANUS STREET
VREDENBURG
7380

TEL: 022 713 2230
FAX: 022 713 5065
EMAIL: ontvangs@wittekruin.co.za

APPLICATION FORM FOR ADMISSION TO HUIS WITTEKRUIN

The following forms must be completed in full:

1. Application form, pages 1 - 5
2. Medical Report, pages 1 - 6
3. Moca Form
4. Report of Social Worker, pages 1 - 3
5. Financial Statement: Client, pages 1 - 4
6. Financial Statement: Proxy / Sponsor, pages 1 - 4
7. Evaluation of degree of Frailty of Residents, pages 1 - 5 [Social Worker]
8. DQ98, pages 1 - 6 [Social Worker]

Please make sure that the forms are correct and fully completed.

It is the responsibility of the applicant or next of kin to keep the Home informed of any change in address or health of the applicant.

With kind regards

Mrs. K. Delport
MANAGER

Badisa

APPLICATION TO SERVICES IN BADISA FACILITY FOR OLDER PERSONS

NAME OF FACILITY: **HUIS WITTEKRUIN**
Uranusstraat
VREDENBURG
7380
Tel.: 022 - 713 2230/9
E-pos: ontvangs@wittekruin.co.za

Indicate need for service with an "X":

Room/Shared Room housing [In Senior Home]	- Independent Living	☐
	- Assisted Living	☐
	- Frail Care	☐
Apartment/Housing	- Independent Living	☐
	- Assisted Living	☐
	- Frail Care	☐
Living Right	- Independent Living	☐
	- Assisted Living	☐
	- Frail Care	☐

1. **SURNAME:** _____
2. **FULL NAMES:** _____
3. **ID.NO:** ☐☐☐☐☐☐ ☐☐☐☐☐☐☐
4. **DATE OF BIRTH:** ☐☐☐☐☐☐☐☐
5. **ADDRESS:** _____

_____

WHERE DO YOU LIVE NOW?

☐ Own Home ☐ Apartment ☐ Children ☐ Hospital
☐ Care Resort ☐ Room/Outside Room/Boarding House ☐ Shelter

6. **APPLICANT: CELL NO:** _____

E-MAIL: _____

7. **PERSON / CHILD WHO CAN BE CONTACTED ON YOUR BEHALF REGARDING YOUR APPLICATION:**

NAME & SURNAME: _____

CELL NO: _____

E-MAIL: _____

8. **GENDER:** ☐ Male ☐ Female

9. **RACE:** ☐ Colored ☐ Indian ☐ Black ☐ White

10. **MARITAL STATUS:** _____

11. **NAME OF LIFE PARTNER:** _____

OR DATE WHEN DECEASED, DIVORCED OR ALIENATED _____

12. **HOME LANGUAGE:** _____

13. **CHURCH INVOLVEMENT:** _____

14. **PREVIOUS/CURRENT WORK:** _____

15. **PERSON/INSTITUTION RESPONSIBLE FOR YOUR FUNERAL COSTS:**

Name: _____

Address: _____

_____

Tel no: _____

Reference no.: _____

16. **NAME OF HOSPITAL AND FILE NO:** _____

17. **NAME OF MEDICAL FUND:** _____

NAME OF PLAN: _____

Medical Aid Number: _____

Doctor: _____ Tel no: _____

18. DETAILS OF ALL CHILDREN (OR RELATIVES IF NO CHILDREN):

Name	Addresses and Tel no's	Relationship	Career
[1]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		
[2]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		
[3]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		
[4]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail		
[5]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail		
[6]	Address:		
	Tel.no:		
	Fax no:		
	Cell. no:		
	E-mail:		

[Please attach separate list, in case of limited space]

19. WHAT IS YOUR HEALTH STATUS, AND WHAT SERVICES DO YOU NEED FROM THE FACILITY? (ie Care Service, laundry service, meals, cleaning etc.)

Medical Diagnosis (i.e. heart problems, high blood pressure or defects):

Allergies:

Do you need help with the following? [Specify]

☐ Mobility

☐ Bathing/wash/eat/getting dressed

20. FINANCIAL MANAGEMENT:

☐ Can do it myself

☐ Need help

☐ Someone manages my finances

If not self, provide the following details (name contact number and kinship) of the person providing assistance. The person who takes a contract with the finance of the residents and who is contracted with must also complete a financial statement as attached to the application package and bank statements.

Name:

Address:

Tel no:

21. WHEN DO YOU WANT TO BE TAKEN IN?

Indicate:
- ☐ Immediately
- ☐ Within 3 months
- ☐ Within 6 months
- ☐ Later

22. Have you previously been taken in a home or Care Resort?

- Indicate **yes**, or **no**: _____
- If **yes,** indicate the facility's details/contact information?

_____

_____

- Explain what the **reasons** are for leaving the facility: _____

_____

_____

_____

23. THE UNDERSIGNED HEREBY DECLARE:

- That the information furnished in this application form is true and precise.
- That a survey will be held in the facility at the service level agreement, the House Rules and regulations that may be amended from time to time.

_____

NAME AND SURNAME: APPLICANT/PROXY REPRESENTATIVE
(If the applicant is unable to sign the form)

_____ _____

SIGNATURE OF APPLICANT (OR PROXY/SPONSOR) **DATE**

_____

NAME AND SURNAME: WITNESS

_____ _____

SIGNATURE OF WITNESS **DATE**

MEDICAL REPORT FOR ADMISSION TO HOME/IMPAIRED DIVISION

1. **FULL NAME AND SURNAME:** _____

2. **AGE:** _____

3. **APPLICANT'S MEDICAL HISTORY AND PREVIOUS TREATMENT:**

_____

_____

_____

_____

_____

4. **GENERAL EXAMINATION:**

Blood pressure reading: _____

HB reading: _____

HGT reading: _____

4.1 **General bodily condition:**

_____

_____

4.2 **Respiratory System:**

_____

_____

4.3 **Heart and Circulatory System**:

_____

_____

4.4 **Urinary System (Urine test please):**

_____

_____

INCONTINENT	Yes	No

If "Yes," specify Incontinent Products:

_____

_____

4.5 **Digestion and other abdominal systems:**

4.6 **Muscle and skeletal system:** (state any deviations)

4.7 **Central nervous system:**

4.8 **Endocrine system:**

4.9 **Other conditions** (Does the patient suffer from any of the following?)

☐ Rheumatism ☐ Chronical osteoarthritis ☐ Venereal disease

☐ Myopathy ☐ Previous Hemiplegia ☐ Infectious Diseases

☐ Parkinson ☐ Skin diseases ☐ Cerebral atrophy ☐ Allergies

4.10 **Does the applicant control his/her excretion functions?**

☐ Yes ☐ No

4.11 **Does the applicant have problems with:** *[Remarks]*

Speech ☐

Balance ☐

Hearing ☐

Sight ☐

Taste ☐

4.12 **Cancer history:** *[Please describe]*

4.13 **Indicate**:

PRIVATE Patient		**STATE Patient**	
DURATION OF TREATMENT:			

5. **HEALTH:** *(make crosses where applicable. If n/a left box open)*

5.1	**MENTAL HEALTH**
Hallucinations/Delirium	
Persecution Delusion	
Other: [*Describe*] _____	

5.2	**ANXIETY**
Psychosomatic	
Obsessive-Compulsive	
Hysteria	
Phobias	

5.3	**DEPRESSION**
Moderately	
Serious	
Endogenous	

5.4	**DEMENTIA**
Vascular Dementia	
Alzheimer's	
Other: Specify _____	

5.5	**PERSONALITY DISORDERS**
Passive dependent	
Passive aggression	

General remarks regarding the above:_____

_____

_____

_____

5.6	**DRUG DEPENDENCE OR ABUSE [specify, e.g. Alcohol / medication]**				
Social					
Chronic					
5.7	**EPILEPSY**	**YES**		**NO**	

Remark: [indicating type of medication]

5.8	**INTELLECTUAL IMPAIRMENT**	**YES**		**NO**	

Remark:

6. CURRENT PSYCHIC/PHYSICAL FUNCTIONING:

6.1 **Personal Functioning:**

6.2 **Orientation regarding change:**

6.3 **Communication proficiency:** [Please describe]

6.4 **Consciousness level: [indicate]**

☐ **Awake** ☐ **Apathetic** ☐ **Sleepy** ☐ **Blunted** ☐ **Passive**

Remarks:

6.5 **Behavior:**

6.6 **Does the applicant regularly need help in regard to his/her mobility, clothing, nutrition, medication and personal hygiene? (Please describe fully where applicable)**

Mobility:

[a] Permanently bedridden ☐ [b] Wheelchair bound ☐

[c] Medical aids ☐

Clothing:

Nutrition:

Medication:

Personal Hygiene:

Skin conditions (e.g. pressure ulcers/ulcers/scabies):

7. **CHRONIC MEDICINE CURRENTLY IN USE/DOSAGE:** [Specify in respect of physical and mental health]

8. **HOW LONG DO YOU TREAT THE PATIENT?** _____

And, if so, briefly indicate the nature and extent of the treatment:

_____

_____

_____

_____

9. **GENERAL REMARKS:**

_____

_____

_____

_____

_____	_____	_____
PHYSICIAN [PRINTING SCRIPT]	**PHYSICIAN [SIGNATURE]**	**DATE**

Address: _____

Tel no: _____

Practice no: _____

E-mail Address: _____

Afrikaanse Weergawe

MONTREAL COGNITIVE ASSESSMENT (MOCA)

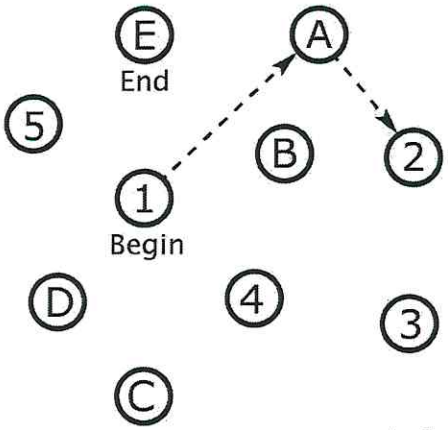
Weergawe 7.1 **www.mocatest.org**

NAAM:

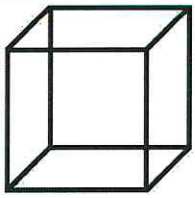
Geslag: DATUM:

Geb: Opleidingsvlak:

VISUORUIMTELIK / UITVOEREND



[ ]



Teken die kubus oor

[ ]

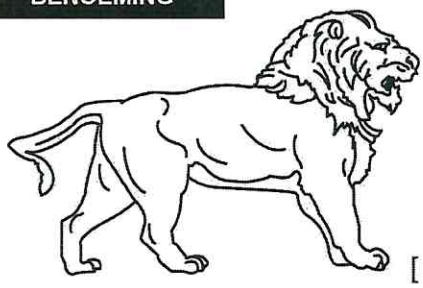
Teken die gesig van 'n horlosie wat tien oor elf aanwys. (3 punte)

[ ] Omlyning [ ] Getalle [ ] Wysers

PUNTE

__/5

BENOEMING



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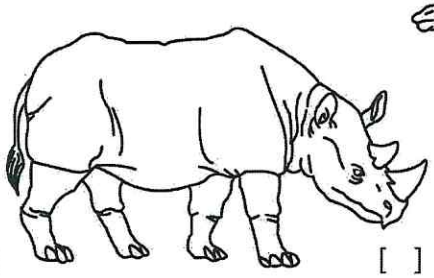

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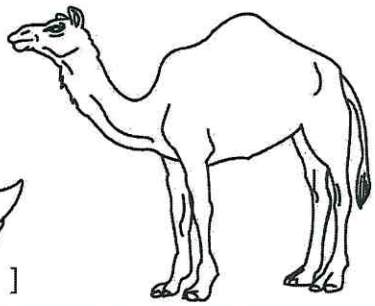

[ ]

__/3

GEHEUE

Lees die lys van woorde. Die proefpersoon moet hulle herhaal. Doen dit 2 keer, selfs al was die eerste poging 'n sukses. Toets herroeping daarvan na 5 minute. (sien onder)

	GESIG	FLUWEEL	KERK	LELIE	ROOI
1ste poging					
2de poging					

Geen punte

AANDAG

Lees die lys van syfers (1 syfer/sek) Proefpersoon moet syfers vorentoe herhaal. [ ] 2 1 8 5 4

Proefpersoon moet syfers agteruit sê. [ ] 7 4 2

__/2

Lees die lys van letters. Met elke letter A moet die proefpersoon met die hand tik. Geen punte ≥ 2 foute.

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Begin seriële 7 aftrekkings by 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 of 5 aftrekkings reg: **3 pte**: 2 of 3 reg: **2 pte**; 1 reg: **1 pt**: 0 reg: **0 pte**

__/3

TAAL

[ ] Herhaal: 'Ek weet net dat Johan die een is wat vandag moet help.'

[ ] 'Die kat het altyd onder die bank weggekruip, wanneer honde in die kamer was.'

__/2

Woordvlotheid: Sê soveel woorde as moontlik in 1 minuut wat begin met die letter 'L'. [ ] _____ (N ≥ 11 woorde)

__/1

ABSTRAKTE DENKE

Ooreenkoms tussen bv. piesang en lemoen = vrugte. [ ] trein - fiets [ ] horlosie - lineaal

__/2

UITGESTELDE HERROEPING

	Moet woorde herroep SONDER 'N WENK	GESIG [ ]	FLUWEEL [ ]	KERK [ ]	LELIE [ ]	ROOI [ ]
Opsioneel	Kategorie wenk					
	Veelkeuse wenk					

Punte slegs vir herroeping SONDER 'n wenk

__/5

ORIËNTASIE

[ ] Datum [ ] Maand [ ] Jaar [ ] Dag [ ] Plek [ ] Stad

__/6

Afrikaanse vertaling: P M Joubert en C W Van Staden

Normaal ≥ 26/30

TOTAAL __/30

Voeg 1 punt by as ≤ 12 jr opleiding

Afgeneem deur: _____

REPORT OF SOCIAL WORKER

1. **SURNAME:** _____

FULL NAMES: _____

DATE OF BIRTH : ☐☐☐☐ ☐☐ ☐☐

ADDRESS:

_____

_____

TELEPHONE NO: _____ [Code:_____]

CELLPHONE NO: _____

2. **FAMILY COMPOSITION AND RELATIONSHIPS:**

_____

_____

_____

_____

_____

_____

3. **PERSONAL DETAILS: [personality, interests, adaptation in group situation, etc.]**

_____

_____

_____

_____

_____

_____

4. **SOCIAL CIRCUMSTANCES:**

Care: ☐ Care for him-/herself ☐ Cared for by children/family/friends/other

Quality Care: ☐ Good ☐ Fairly ☐ Insufficient

Social Contacts: ☐ Sufficient contact with family/ extended family/friends

☐ Contact very limited ☐ Lonely

Social adaptation: ☐ Well-adapted ☐ Social situation difficult

☐ Depressed ☐ Behavioural Problems

Motivation:

_____

_____

_____

_____

5. ENVIRONMENTAL AND HOUSING CONDITIONS [Living conditions, motivation for recording, home problems]:

_____

_____

_____

_____

5.1 **CURRENT HOUSING:** ☐ Own Home ☐ Rental House ☐ Boarding House

☐ Home for the elderly ☐ Hospital ☐ Live with others

☐ Live with children ☐ Apartment ☐ Shelter ☐ Retirement Resort

5.2 **Certainty concerning current accomodation:** ☐ Indefinite ☐ Uncertain

☐ Must leave ☐ Can stay, but circumstances not suited for elderly

Provide Reasons:

_____

_____

_____

_____

6. PHYSICAL AND PSYCHIC CONDITION:

Is the applicant able to:

	YES or **NO** to **SOME DEGREE** *(indicating with √)*		
6.1 **Physically**			
* Preparation and cooking of own meals	☐	☐	☐
* Keep the house clean	☐	☐	☐
* Bath themselves	☐	☐	☐
* Dress themselves	☐	☐	☐
* Eating without assistance	☐	☐	☐
* Move around freely and without assistance	☐	☐	☐

Health: (*Indicate with √*) ☐ Good ☐ Erratic ☐ Weak

6.2 **PSYCHIC: [poor memory, comprehension, depression, psychosis, aggressive behaviour**

Check mark. [√] ☐ Clear Thoughts ☐ Forgetful

☐ Signs of carelessness ☐ Clear signs of dementia

Psychiatric report attached? ☐ Yes ☐ No

6.3 **Drug dependence:** [alcohol, marijuana, prescription medications, etc.]

7. **ECONOMIC CIRCUMSTANCES:**

8. **REASONS FOR ADMITTANCE: [age, social circumstances, home problems, bodily and physical impairment, economic circumstances, concatenation]:**

9. **SERVICES ALREADY RENDERED: [as well as other home applications]**

10. **RECOMMENDATION: [Specify type of placement, e.g. room, sick bay, flat]**

11. **MOTIVATION REGARDING NON-ELDERLY/DISABLED:**

12. **How long is the applicant known to you?** _____

SOCIAL WORKER **NAME OF ORGANIZATION** **DATE**

Registration No.: Social worker

FINANCIAL DECLARATION CLIENT

[Documentary evidence of all income/expenses and assets/liabilities must be attached as well as 3 months of bank statements.]

NAME OF APPLIANT: _____

DATE OF RETURN: _____

A. INCOME

1.	SALARY/PENSION RECEIVED (state type of pension) payment point (e.g. bank, Post Office)		Reference / Account Number	MONTHLY INCOME Own	Spouse
1.1					
1.2					
1.3					
2.	**ANNUITIES (give the name of fund)**				
2.1					
2.2					
2.3					
3.	**INCOME FROM TRUST FUNDS AND MAINTENANCE FEES (state name of Fund/person)**				
3.1					
3.2					
4.	**SHARES (state name of company)**				
4.1					
4.2					
4.3					
5.	**Directors' FEES (state name of company)**				
5.1					
6	**CASH INVESTMENTS I .o.w. all rents that are earned either on fixed deposits, savings rack. Etc. (Specify financial settings)**	**Amount invested or balance**			
6.1					
6.2					
6.3					
6.4					
6.5					
6.6					
6.7					

7.	FIXED PROPERTY RENTAL REVENUE: (i.e. Farms, homes) full definition and where situated	Market valuation	Outstanding Regard		
7.1					
7.2					
7.3					

SUBTOTAL CARRIED OVER			R	R
8. OTHER SOURCES OF INCOME (I.e. Income from business, fruit use crypto money, etc.). Specify, please		Reference/Account Number	Own	Spouse
8.1				
8.2				
8.3				
8.4				
		TOTAL	R	R

B. DECLARATION IN RESPECT OF ASSETS SOLD OR DONATIONS MADE:
(please complete fully)

1. Did you sell or gift any assets (immovable property) away?
If so, please give the following details:

[a] Assets sold: [description] _____

[i] Date sold: _____

[ii] Gross Sales Price: R_____

[iii] Little sales fees [specify on separate paper, please.] R_____

[iv] Netto yield R_____

[b] Assets Present: [description] _____

[i] Date donated: _____

[ii] Value: R_____

[c] Cash donated: [description] _____

[i] Date donated: _____

[ii] Amount donated: R_____

2. **Expenses THAT MAY BE CLAIMED** *[documentary proof must please.be provided]*

2.1 Medical

2.1.1 Funeral Policy Premium: R_____
2.1.2 Medical aid contributions: [own portion] R_____
2.1.3 Chronic medicine: [only in exceptional cases] R_____

2.2 Rent Income from real estate

2.2.1 Rates: R_____

2.2.2 Building Insurance: R_____

2.2.3 Mortgage installment: R_____

TOTAL: R_____

I declare that the above information is provided by me truly and correct.

SIGNATURE OF:

_____ **DATE:** _____

CLIENT

_____ **DATE:** _____

PROXY/SPONSOR

NB: Interest revenue must be substantiated by balance certificates from financial institutions. False statements are a culpable offence.

DECLARATION

I certify that, before I declined the prescribed oath/confirmation, I set the following questions to the declarant and wrote his/her answers in my presence:

(a) Are you familiar with the content of the above statement and do you understand it?
Answer: _____

(b) Do you have any objection to the laying of the prescribed oath?
Answer: _____

(c) Do you consider the prescribed oath as binding to your conscience?
Answer: _____

I certify that the declarant is familiar with the content of the declaration and understands it. This statement has been sworn/confirmed before me and the declarant's a signature/thumbprint/Mark has been installed on it in my presence.

---------- ----------
COMMISSIONER OF OATHS PLACE

DATE

STAMP

FOR OFFICE USE

NET INCOME R_____
BOARDING PER MONTH R_____

FOR OFFICIAL USE BY SELECTION OFFICER: DEPARTMENT OF SOCIAL DEVELOPMENT

Total gross income: R_____
Few approved deductions [specify]
[a] _____ R_____
[b] _____ R_____
[c] _____ R_____
[d] _____ R_____

Net income: R_____

Income Group Code [ ]

OFFICIAL–DEPARTMENT: SOCIAL DEVELOPMENT

DATE: _____

FINANCIAL DECLARATION PROXY/SPONSOR

[Documentary evidence of all income/expenses, assets and liabilities must be attached as well as 3 months bank statements]

NAME OF PROXY/SPONSOR: _____

DATE OF RETURN: _____

A. INCOME

1.	SALARY/PENSION RECEIVED (state type of pension) payment point (e.g. bank, post Office)		Reference / Account Number	MONTHLY INCOME Own	Spouse
1.1					
1.2					
1.3					
2.	ANNUITIES (give name of fund)				
2.1					
2.2					
2.3					
3.	INCOME FROM TRUST FUNDS AND MAINTENANCE FEES (state name of Fund/person)				
3.1					
3.2					
4.	SHARES (state name of company)				
4.1					
4.2					
4.3					
5.	Directors' FEES (state name of company)				
5.1					
6	CASH INVESTMENTS i.o.w. all rents that are earned either on fixed deposits, savings rack. Etc. (Specify financial settings)	Amount invested or balance			
6.1					
6.2					
6.3					
6.4					
6.5					
6.6					
6.7					

7.	FIXED PROPERTY RENTAL REVENUE: (i.e. Farms, homes) full definition and where situated	Market valuation	Outstanding Regard		
7.1					
7.2					
7.3					

SUBTOTAL CARRIED OVER			R	R
8. OTHER SOURCES OF INCOME (I.e. Income from business, fruit use crypto money, etc.). Specify, please		Reference / Account Number	Own	Spouse
8.1				
8.2				
8.3				
8.4				
		TOTAL	R	R

B. DECLARATION IN RESPECT OF ASSETS SOLD OR DONATIONS MADE:
[please complete fully]

1. Did you sell or gift any assets (immovable property)?
If so, please give the following details:

[a] Assets sold: [description] _____

[i] Date sold: _____

[ii] Gross Sales Price: R_____

[iii] Little sales fees [specify on separate paper, please.] R_____

[iv] NET yield: R_____

[b] Assets Present: [description] _____

[i] Date donated: _____

[ii] Value: R_____

[c] Cash donated: [description] _____

[i] Date donated: _____

[ii] Amount donated: R_____

2. **EXPENSES** [List total monthly expenditure fully]

ITEM	AMOUNT
TOTAL	

I declare that above information provided by me is truthful and precise.

DATE: _____

PROXY/SPONSOR

NB: Interest revenue must be substantiated by balance certificates from financial institutions. False statements are a culpable offence.

DECLARATION

I certify that, before I declined the prescribed oath/confirmation, I set the following questions to the declarant and wrote his/her answers in my presence:

(a) Are you familiar with the content of the above statement and do you understand it?
Answer: _____

(b) Do you have any objection to the laying of the prescribed oath?
Answer: _____

(c) Do you consider the prescribed oath as binding to your conscience?
Answer: _____

I certify that the declarant is familiar with the content of the declaration and understands it. This statement has been sworn/confirmed before me and the declarant's signature/thumb print/Mark has been installed on it in my presence.

_____ _____
COMMISSIONER OF OATHS **PLACE**

_____
DATE

STAMP

FOR OFFICE USE

NET INCOME R_____
BOARDING PER MONTH R_____

FOR OFFICIAL USE BY SELECTION OFFICER: DEPARTMENT OF SOCIAL DEVELOPMENT

Total gross income: R_____
Few approved deductions [specify]
[a] _____ R_____
[b] _____ R_____
[c] _____ R_____
[d] _____ R_____

Net income: R_____

Income Group Code ☐

_____
OFFICIAL–DEPARTMENT: SOCIAL DEVELOPMENT

DATE: _____

DEPARTMENT OF SOCIAL DEVELOPMENT FOR SUSTAINABLE COMMUNITIES | DEPARTEMENT VAN MAATSKAPLIKE ONTWIKKELING VIR VOLHOUDBARE GEMEENSKAPPE | ISEBE LOPHUHLISO LOLUNTU FOR SUSTAINABLE COMMUNITIES

EVALUATION OF DEGREE OF FRAILTY OF RESIDENTS IN A FACILITY
EVALUERING VAN GRAAD VAN VERSWAKTHEID VAN INWONERS

Name of resident Naam van inwoner	

ID No:	

Fill in points in the appropriate block. (Four columns are provided for periodic evaluation)
Vul die punte in die blokkie teenoor die toepaslike item. (Vier kolomme is voorsien vir periodieke evaluering)

Points Punte	Evaluation / Evaluering			
	1st	2nd	3rd	4th
0				
2				
3				

1. **MOBILITY**
MOBILITEIT

(a) Able to move about independently, with or without the help of aids.
Beweeg onafhanklik, met of sonder hulpmiddels.

(b) Able to move about with a walking stick/walking frame/wheelchair with some assistance or supervision.
Beweeg met behulp van kierie/llooppraam/rolstoel met gedeeltelike hulp of toesig.

(c) Only able to move with assistance from a staff member.
Beweeg slegs met behulp van personeellid

Points Punte	Evaluation / Evaluering			
	1st	2nd	3rd	4th
4				

(d) Bedridden and/or totally dependent on assistance / needs to be transferred from bed to chair.
Bedlêend en/of totaal afhanklik van hulp/moet oorgeplaas word van bed na stoel.

2. **PERSONAL HYGIENE**
PERSOONLIKE HIGIëNE

2.1 <u>Care of hands, face & feet</u>
<u>Versorging van hande, gesig & voete</u>

(a) Copes without assistance Doen dit selfstandig	0				
(b) Needs supervision Het toesig nodig	1				
(c) Needs assistance for example with cutting of nails. Het hulp nodig, byv knip van naels	2				
(d) Totally dependent Totaal afhanklik	3				

2.2 <u>Oral Hygiene</u>
<u>Mondsorg</u>

(a) Copes without assistance Doen dit selfstandig	0				
(b) Needs supervision brushing teeth Toesig nodig met tandeborsel	1				
(c) Needs assistance brushing teeth Het hulp nodig met tandeborsel	2				
(d) Totally dependent Needs care and use of mouthtray Totaal afhanklik. Mondbad nodig	4				

2.3 Bath / Bad:

(a) Copes without assistance
Doen dit selfstandig

(b) Needs to be motivated and supervised
Moet aangespoor word en het toesig nodig

(c) Needs assistance. / Het hulp nodig

(d) Dependent – Has to be bathed.
Afhanklik – Moet gebad word

Points Punte	Evaluation / Evaluering			
	1st	2nd	3rd	4th
0				
1				
2				
4				

2.4 Shaving and Care of hair

Skeer- en Haarversorging

(a) Independent, copes without assistance to an acceptable standard of neatness
Selfstandig, Doen dit aanvaarbaar tov netheid

(b) Needs supervision. Het toesig nodig

(c) Needs assistance. / Het hulp nodig

(d) Totally dependent. / Totaal afhanklik

0				
1				
2				
3				

3 **NUTRITION**
VOEDING

(a) Eats without assistance
Eet selfstandig

(b) Can eat, but needs supervision
Kan self eet, maar het toesig nodig.

(c) Needs some assistance, cutting meat, buttering of bread or must be encouraged to eat
Het gedeeltelik hulp nodig byv sny van vleis, smeer van brood of moet aangemoedig word om te eet.

(d) Needs to be fed. / Moet gevoer word

(e) Tube fed. / Buisvoeding

0				
1				
2				
3				
4				

4 **CLOTHING**
KLEDING

(a) Independent, dresses and undresses self
Trek selfstandig aan en uit

(b) Needs supervision dressing and undressing

Het toesig nodig met aan en uit trek van klere

(c) Needs assistance with dressing and undressing e.g. buttons zips

shoelaces
Het hulp nodig om klere aan en uit te trek

(d) Totally dependent on assistance with dressing and undressing
Totaal afhanklik van hulp met aan- En uittrek van klere

Points Punte	Evaluation / Evaluering			
	1st	2nd	3rd	4th
0				
1				
2				
3				

5 **VISION**
GESIGSVERMOë

(a) Blind or partially sighted, but able to cope independently
Blind of swaksiende, maar in staat Om selfstandig te funksioneer

(b) Blind or partially sighted – needs some assistance
Blind of swaksiende – benodig gedeeltelik hulp

(c) Blind – totally dependent on assistance
Blind – deurlopend afhanklik van hulp

0				
1				
3				

6 **HEARING**
GEHOOR

(a) Deaf or hard-of-hearing, but able to cope independently
Doof of hardhorend, maar in staat Om selfstandig te funksioneer

0				

		Points Punte	Evaluation / Evaluering 1st	2nd	3rd	4th
(b)	Deaf or hard-of-hearing. Communicates with difficulty Doof of hardhorend. Kommunikeer moeilik	1				
(c)	Totally deaf to the extent that it constitutes a risk or problem to himself / herself and/or others Totaal doof. Doofheid is 'n risiko vir himself / haarself en/of ander en/of 'n probleem vir ander	3				
7	**TREATMENT** **BEHANDELING**					
7.1	Medication / Medikasie					
(a)	Takes medication without assistance or supervision Gebruik medikasie selfstandig	0				
(b)	Takes own medication without assistance but monthly supervision is necessary. Medication needs to be ordered for resident. Gebruik medikasie onafhanklik maar maandelikse kontrolering is nodig. Medisyne moet vir inwoner bestel word.	1				
(c)	Medication has to be administered, but does not need assistance with taking medicine Medikasie word toegedien. Benodig egter geen spesiale hulp met inname nie.	2				
(d)	Assistance is needed to take medicine Medikasie word met hulp toegedien	4				
7.2	Care of pressure areas Versorging van drukpunte					
(a)	None Geen	0				
(b)	At least 3 times per day Minstens 3 keer per dag	1				
(c)	Every 4 hours ;/ Elke 4 uur	2				
(d)	Every 2 hours / Elke 2 uur	3				

		Points Punte	Evaluation / Evaluering 1st	2nd	3rd	4th
8	**TOILET HABITS** **TOILETGEWOONTES**					
	Continence of urine and faeces Kontinensie van urine en ontlasting	0				
(a)	Normal, independent, in full control Of bowel and bladder functions Normaal, selfversorgend, volle beheer oor organe					
(b)	Experiences problems with stress Incontinence or slight Incontinence. Able to care for self, but needs encouragement to do better bladder training exercises./ Needs supervision with use of toilet Ervaar probleme met druklek of geringe inkontinensie. Tref eie voorsorg, maar moet aangemoedig word om blaasbeheeroefeninge te doen. Het toedig nodig met gebruik van toilet.	1				
(c)	Occasionally incontinent of urine or faeces. Special measures not taken / Periodieke ongelukke vind plaas sonder voorsorg getref word.	2				
(d)	Total incontinence of urine and faeces / Totale inkontinensie van urine of ontlasting	3				
(e)	Needs catheter and/or colostomy Care / Benodig katerer- en/of kolostomiesorg	4				
9	**TERAPEUTIC ACTIVITIES, HANDCRAFT,EXERCISES & INFO.** **TERAPEUTISE AKTIWITEITE<HANDVAARDIGHEDE, OEFENINGE & INFO**					
(a)	No motivation / assistance needed Geen motivering / hulp nodig nie	0				
(b)	Needs assistance 15min. per day Hulp benodig 15minute per dag	1				
(c)	Needs assistance 30min per day Hulp benodig 30 minute per day	2				
(d)	Needs help for more than 60min. Hulp benodig meer as 60minute pd	3				

10 MENTAL STATUS
GEESTESTOESTAND

		Points Punte	Evaluation / Evaluering 1st	2nd	3rd	4th
10.1	Memory / Geheue					
(a)	Memory good, functioning independently Geheue goed, funksioneer selfstandig	0				
(b)	Forgetful, e.g. misplaces articles & clothing Vergeetagtig, byv. artikels & kleding word verlê	1				
(c)	Totally disturbed, confused. Displays antisocial behaviour / aggressive / apathetic Totaal versteurd, verward. Operbaar anti-sosiale gedrag. Raak aggresief / Apaties	4				
10.2	Emotional Support (Counselling & Support) Emosionele Steun (Beraad & Ondersteuning)					
(a)	No support needed Geen steun nodig nie	0				
(b)	Support needed, 15-30 minutes per day Steun nodig, 15-30 minute per dag	2				
(c)	More than 30minutes support needed per day Meer as 30minute steun nodig per dag	3				
10.3	Comprehension and Communication ability Begrips- en Kommunikasievermoë					
(a)	Normal communication Normale kommunikasie	0				
(b)	Communication so poor at times that needs cannot be made known Kommunikasie soms so swak dat behoeftes nie bekend gemaak kan word nie	1				
(c)	Needs cannot be made known at all Behoeftes kan glad nie bekend gemaak word nie	3				

		Points Punte	Evaluation / Evaluering 1st	2nd	3rd	4th
10.4	Orientation re: time, place & person Orientasie tov tyd, plek & persoon					
(a)	Normal / Normaal	0				
(b)	Sometimes disorientated Soms gedisoriënteerd	1				
(c)	Often disorientated, restless, wanders Dikwels gedisoriënteerd, rusteloos, dwaal rond	2				
(d)	Always disorientated re time,place & person, but does not disturb others Deurlopend gedisoriënteerd tov tyd plek & persoon, maar steur nie ander nie.	3				
(e)	Apathetic / totally disorientated re time, place & person. Gets lost, Must be watched. Disturbs others Apaties / algehele disoriëntasie tov Tyd, plek & persoon. Verdwaal, Moet opgepas word. Steur ander.	4				
	TOTAL / TOTAAL					

KEY TO POINT ALLOCATION / SLEUTEL TOT PUNTETELLING:

Group / Groep: 1	Selfcare/ selfsorg	0 – 11
Group / Groep: 2	Medium care / Matige sorg	12 – 25
Group / Groep: 3	Maximum care / Maksimale sorg	26 +

Group classification of older person/disabled person:
Groepindeling van ouer persoon/ gestremde persoon:

	Group / Groep	DATE / DATUM	SIGNATURE / HANDTEKENING
1st Evaluation			
2nd Evaluation			
3rd Evaluation			
4th Evaluation			

DEPARTMENT OF SOCIAL DEVELOPMENT FOR SUSTAINABLE COMMUNITIES
DEPARTEMENT VAN MAATSKAPLIKE ONTWIKKELING VIR VOLHOUBARE GEMEENSKAPPE
ISEBE LOPHUHLISO LOLUNTU FOR SUSTAINABLE COMMUNITIES

Screening Certificate
Keuringsertifikaat

For admission and subsidising of older persons and/or persons with disabilities
Vir opname en subsidiëring van ouer persone en/of persone met gestremdhede.

1 Submit one certificate only.
Dien slegs een sertifikaat in.
2 The Departmental Screening Officer completes the certificate at the time of screening and verifies the nett income from the applicant's Statement of Income and Expenditure.
Die Departementele Keuringsbeampte voltooi die sertifikaat tydens keuring en bevestig die netto inkomste vanaf die applicant se Verklaring van Inkomste en Uitgawes.
3 #The residential facility inserts this date as soon as the applicant has been admitted.
Die residentiële vul hierdie datum in spdra die applicant opgeneem is.
4 The certificate must be submitted together with the claim for subsidy i.r.o the person concerned.
Die sertifikaat moet tesame met die eis om subsidie t.o.v die betrokke persoon ingedien word.

Name of Applicant / Resident / Naam van Applikant / Inwoner

Date of Birth / Geboortedatum

Pension Number / Pensioennommer

Nature & amount of nett income p.m. / Aard & bedrag van netto inkomste p.m.

R

Income Code/ Inkomstekode

If married, combined income p.m.
Indien getroud, gesamentlike inkomste p.m.

R

Date screened or rescreened / Datum gekeur of herkeur

Group 1 Groep 1 | Group 2 Groep 2 | Group 3 Groep 3 | Economic Ekonomies

Name of Facility / Naam van Tehuis

Date Admitted / Datum Opgeneem

#

Departmental Date Stamp / Departementele Datumstempel

Departmental Official / Departementele Beampte

DEPARTMENT OF SOCIAL DEVELOPMENT FOR SUSTAINABLE COMMUNITIES
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#

Departmental Date Stamp / Departementele Datumstempel

Departmental Official / Departementele Beampte

Electronic Format

ASSESSMENT FOR ADMISSION TO HOMES FOR FRAIL PERSONS / SUPPORT NEEDS FOR OLDER PERSONS

DQ98

[Do not write in the shaded areas. Tick where appropriate.]

SECTION 1: REGISTRATION DETAILS

A. ORGANISATION:	Registration No:	Date of registration:
Date of notification:	Assessment completed on:	Date of admission:

Type of Assessment:	Urgency:	Place of Assessment:	
☐ New notification	☐ Within 24 hours	☐ Own dwelling	☐ Hospital
☐ Revision	☐ Within 1 week	☐ Home for Aged	☐ Clinic
☐ Re-assessment	☐ Within 1-3 weeks	☐ Sheltered accommodation	☐ Other .....
☐ Appeal	☐ Other	☐ Community Centre	

Reason for referral:	Assessor's name	Occupation	Reference source:
			☐ Centre member

B. CLIENT'S PERSONAL DETAILS:

Surname:	Marital Status:	☐ Nursing services
Full name:		☐ Group (Club)
First name and initials:		
Address:		☐ Social worker
		☐ Church
		☐ Hospital
Tel No:		☐ Family member
Date of birth/Age: (ID Number)	Gender: M F	☐ Other .....
Race: *(for statistical purposes)*	ACCOMMODATION:	FAMILY COMPOSITION:

SOURCE OF INCOME:	GROSS INCOME PER MONTH:
☐ Disability Grant	☐ Individual ☐ Couple
☐ Old Age Pension	Total Monthly Income per household:
☐ War Veterans	R
☐ Other (private)	

ACCOMMODATION:	FAMILY COMPOSITION:
☐ Owner	☐ Lives in old age home
☐ Tenant	☐ Lives alone
☐ House	☐ With spouse
☐ Flat	☐ With children/child
☐ Retirement complex	☐ With other family
☐ Private home/guest house/ hotel	☐ With other elderly
☐ Informal /Squatter settlement	☐ With non-family (friends)
☐ Housing scheme	☐ Extended family
☐ Tribal (rural)	☐ Rural extended family
☐ Farm labourer	☐ With parents
☐ Old age home	☐ Please state number of persons in the household
☐ Other	

Specify details of financial dependants:

MEDICAL CONDITIONS / OTHER PROBLEMS	

C. NEEDS IDENTIFIED BY CLIENT	Additional information obtained from:			
		Applicant him / herself		Caregiver
		Family		Social worker
		Medical personnel		Other

D. DETAILS REGARDING NEXT OF KIN / CARE-GIVER:

Next of kin: Relationship: Spouse /son /daughter /other Age (Optional): Address: Telephone no: Work: Home:	Next of kin: ..... Relationship: Spouse /son /daughter /other : Age (Optional) Address: ..... Telephone no: Work: Home:

SECTION 2: ASSESSMENT:

A: Urgent Evaluation Criteria

	Bed bound
	Mentally disabled with total incontinence
	Chronic high risk medical conditions requiring continuous nursing care

Medical conditions / diagnoses:

B CRITERIA FOR ADMISSION: 1. SKILLED CARE:

a. Pressure care:

0	Nil needed
11	1 to 3 x per day
22	Every 4 hours
33	Every 2 hours

b. Specialised care:

0	Requires no care / dressings
11	Simple, daily treatment or dressings
42	Requires complicated treatment /dressings more than 3 x per day

Other specialised care required /comments:

c. Night-care:

0	No or infrequent night care required
5	Regular, 1 x per night care required
10	Regularly requires attention at least 3 x per night
25	Usually awake, restless, disturbs others

Total Score "Skilled care"	a:	+	b:	+	c:	=	

Current medication:

2. ACTIVITIES OF DAILY LIVING (ADLs)

Eating	Dressing upper	Dressing lower	Personal hygiene	Bathing	Toileting	Medications	Mobility	Communication	Transfers	
0	0	0	0	0	0	0	0	0	0	Fully independent
3	1	2	2	1	3	3	2	2	0	Independent with aid-devices
3	1	2	2	1	3	5	4	N/A	2	Needs supervision, but can manage on own
3	2	3	2	2	5	8	6	6	2	Needs regular supervision and help with certain tasks
10	3	4	6	4	8	10	6	6	9	Needs help of one person
N/A	6	8	N/A	6	10	N/A	8	N/A	11	Needs help of two persons
13	N/A	N/A	10	N/A	13	13	10	10	N/A	Needs continuous care
										SCORE FOR EACH ITEM
									0	**TOTAL SCORE FOR "ADLs"**

REMARKS:

3. MENTAL FUNCTIONING

0	No support required
3	Observes accepted social standards with support
3	Behaviour is unusual but does not offend others or endanger self
13	Behaviour disturbing to others at times but not a danger to self or others
23	Continuous, uncontrollable, demanding behaviour
25	Behaviour dangerous / risk to him/herself / other people
	REMARKS; eg Markedly unmotivated / lonely / depressed / aggressive

Yes	No	
		Would the client benefit from a Psychiatric assessment?

TOTAL SCORE for "Mental functioning"	

4. PRIMARY NEEDS				
Water	Food	Toilet	Safety	Key
0	0	0	0	Available
11	11	8	10	Limited
22	22	16	20	Inaccessible / dangerous
28	28	20	24	Not available
TOTAL SCORE FOR "PRIMARY NEEDS" :				

Not applicable (institutionalised)

5. COMMUNITY INFRASTRUCTURE			
Transport	Telephone	Post Office	
			Available
			Limited
			Inaccessible
			Not available

Not applicable (institutionalised)

6.SUPPORT SYSTEMS AVAILABLE TO CLIENT	
0	Support system (spouse, family, friends) functioning well
20	Support system available, but not functioning well
3	Living alone with access to other support systems
13	Only formal support systems
33	Support system available, but exploitation / abuse / neglect suspected
26	No support system available
	Section 6 score

Not applicable (institutionalised)

7. GENERAL FUNCTIONING OF CARE-GIVER:	
0	Care-giver fully in control of the situation
7	Requires some support
7	Not healthy / aged / disabled
40	Requires continuous support / help
67	Total incapacity to provide care
67	Total burnout
	Section 7 score
0	**TOTAL SCORE Section 6 + 7 "Carer"**

Not applicable (institutionalised)

8. OTHER PERSONS INVOLVED IN ASSESSMENT			
	Family practitioner		Physiotherapist
	District surgeon		Social worker
	Nursing personnel		Old age home personnel
	Specialist geriatrician / psychiatrist		Care-giver
	Traditional healer		Home care personnel

SECTION 3: KEY TO ASSESSMENT FOR SERVICE REQUIREMENT			
Score from "Skilled" (Section 1)	0	0.2	0
Score from "ADLs" (Section 2)	0	0.25	0
Score from "Mental" (Section 3)	0	1	0
Score from "Primary" (Section 4)	0	0.15	0
Total score "Carer" (Section 6 & 7)	0	0.15	0
DQ98 INDEX SCORE		**Total**	**0**

FINDINGS:			
Requires institutional care	Yes	No	
If Yes, Specify care type required :			
Temporary		Permanent	
Respite (care-giver relief)		Terminal	
Rehabilitation			

Additional information :

SECTION 4: RECOMMENDATION:

Admission to home for the aged		Referral for community health services		
If Admission Recommended		Community services	Yes	No
Urgent		Medical services	Yes	No
As soon as possible		Geriatric services	Yes	No
Other:		Psychiatric services	Yes	No
Re-assess: Date:		Referred to:		Date:

Community support service recommendation:

No additional support services recommended		Additional support by means of certain home care services	

Indicate which services are currently "in use" or "required":

	Required	In Use
Day care (at home)		
Meals-on-wheels		
Home help		
Bed bath (personal care)		
Frail care (institutional)		
Hospital care		

	Required	In Use
Day Care (Centre)		
Respite care (relief)		
Nursing services		
Social work care		
Other		
Centre programmes (clubs)		

	Required	In Use
Occupational therapist		
Physiotherapist		
After-care rehabilitation		
Garden service		
Assisted living		
Support group		

SECTION 5: CONCLUSION OF ASSESSMENT

(Delete where appropriate)

Assessor: I have discussed the current assessment and recommendations with the applicant / care-giver and have indicated the right to appeal.

Signature: ..... Date: .....

Applicant / Caregiver: I have discussed the assessment, recommendations and appeal procedure with the assessor.

I agree / disagree with the recommendation.
I agree / disagree that the assessment form be referred to Community Services.
I agree / disagree that the assessment form be referred to the following organisation: .....

Motivate (if disagreement) .....

Signature: .... Date: .....

Client referred to: ..... Date : ....