



# LIONS NURSING HOME

**A JOINT PROJECT**

LIONS CLUB OF KUCHING HOST  
 LIONS CLUB OF SERIAN  
 LIONS CLUB OF KUCHING METRO  
 LIONS CLUB OF KUCHING CITY  
 LIONS CLUB OF KUCHING NORTH  
 LIONS CLUB OF KUCHING COSMOPOLITAN  
 LIONS CLUB OF STAMPIN PENDING

LIONS CLUB OF KUCHING ALLAMANDA  
 NEW CENTURY LIONS CLUB KUCHING EMERALD  
 LIONS CLUB OF KUCHING IXORA  
 LIONS CLUB OF BAU  
 LIONS CLUB OF KUCHING HORNBILL  
 LIONS CLUB OF KOTA SAMARAHAN

PATRON : DATUK AMAR PUAN SRI HAJJAH LAILA TAIB D.A.

Our Ref: \_\_\_\_\_ Your Ref: \_\_\_\_\_ Date: \_\_\_\_\_  
**APPLICATION FOR ADMISSION TO LIONS NURSING HOME, KUCHING**

NAME: \_\_\_\_\_  
 NRIC: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_  
 RACE: \_\_\_\_\_ DIALECT: \_\_\_\_\_ RELIGION: \_\_\_\_\_

**MEDICAL INFORMATION**

Please complete the following sections as fully as possible and tick ( ) where relevant.

1. **Diagnosis** \_\_\_\_\_  
 History of illness \_\_\_\_\_  
 \_\_\_\_\_  
 Previous hospitalization ( ) Yes, Hosp. \_\_\_\_\_  
 ( ) No.

2. Type(s) and date(s) of **operation**, if any \_\_\_\_\_  
 \_\_\_\_\_  
**Allergies** (e.g. food, medicine, others.) ( ) Yes, Specify \_\_\_\_\_  
 ( ) No.

3. **Present treatment**

(a) Medication (give details) \_\_\_\_\_  
 (b) Dressing (give details) \_\_\_\_\_  
 (c) Physiotherapy ( ) Yes ( ) No  
 (d) Occupational Therapy ( ) Yes ( ) No

4. Does patient require regular follow-up at Specialist Clinics ? ( ) Yes ( ) No

Specify \_\_\_\_\_

5. **CONDITION OF PATIENT**

Is patient in constant pain and needs heavy sedation? ( ) Yes ( ) No

Physical State ( ) Satisfactory ( ) Weak ( ) Pale  
( ) Respiratory disorders ( ) Pain ( ) Dehydrated  
( ) Others \_\_\_\_\_

Mental State ( ) Alert ( ) Drowsy ( ) Anxious  
( ) Confused ( ) Restless ( ) Others \_\_\_\_\_

Vision ( ) Intact ( ) Impaired, specify \_\_\_\_\_

Hearing ( ) Intact ( ) Impaired, specify \_\_\_\_\_

Speech ( ) Normal ( ) Impaired, specify \_\_\_\_\_

Skin ( ) Normal ( ) Impaired, specify \_\_\_\_\_

Mouth ( ) Clean ( ) Ulcer ( ) Dentures

Joint Contractures ( ) Yes ( ) No

Others \_\_\_\_\_

6. **MOBILITY STATUS**

(a) Independent ( ) Yes ( ) No

(b) Partially dependent ( ) Yes ( ) No  
(i.e. using aids, appliances, help, wheelchair)  
Give details if Yes

(c) Totally dependent ( ) Yes ( ) No

7. **IF TOTALLY DEPENDENT (NON-AMBULANT)**

(i) Feeding ( ) Able to feed self.  
( ) Needs assistance in feeding.  
( ) Tube feeding.  
( ) Others/Specify \_\_\_\_\_

- (ii) Toilet
  - ( ) Able to attend to own toilet needs.
  - ( ) Needs assistance in toilet needs.
  - ( ) Incontinent of bladder.
  - ( ) Incontinent of bowel.

8. **Prognosis** \_\_\_\_\_

9. If patient is currently in Hospital/Institution, please submit a medical report from the Hospital/Institution.

10. Any other relevant information:

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Attending Doctor

\_\_\_\_\_

Name and Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Please note that due to limited facilities at the Lions Nursing Home, the following type of cases may not be given priority for admission:-

- (i) Patients undergoing Radiotherapy.
- (ii) Patients with bed pressure sores requiring surgery.
- (iii) Patients who require regular follow-up at hospitals.
- (iv) Patients whose treatment requires laboratory monitoring.

## SOCIAL INFORMATION

1. Patient has a home  Yes  No

2. Patient has a home but:

- has no relatives or friends to help him/her
- requires more care than is available at home
- home conditions are unsuitable for his/her return from hospital

3. Particulars of members of patient's family (including those living apart)

NAME	MARITAL STATUS	RELATIONSHIP TO PATIENT	NRIC NO	OCCUPATION	NETT MONTHLY INCOME

4. Name of person who will be responsible for patient's Nursing Home Charges (give also NRIC No. Address and Telephone No.)

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5. Name of person to contact if patient dies (give also address and telephone no. if different from 4)

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6. Patient's financial status (give reference number and amount if patient is receiving aid/pension. State amount if patient has savings)

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7. Reasons for seeking admission \_\_\_\_\_  
\_\_\_\_\_
8. Length of stay (short-term or long-term) \_\_\_\_\_
9. Whether relatives and friends are agreeable to discharge later on. \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Guardian

- Note: (i) This is a nursing home which provides rehabilitation and basic nursing care for convalescing elderly Patients – **not a Hospital.**
- (ii) You are encouraged to request your usual family doctor to come and provide follow-up treatment for the patient.
- (iii) If any medicine is needed, you are to provide your own medicine.