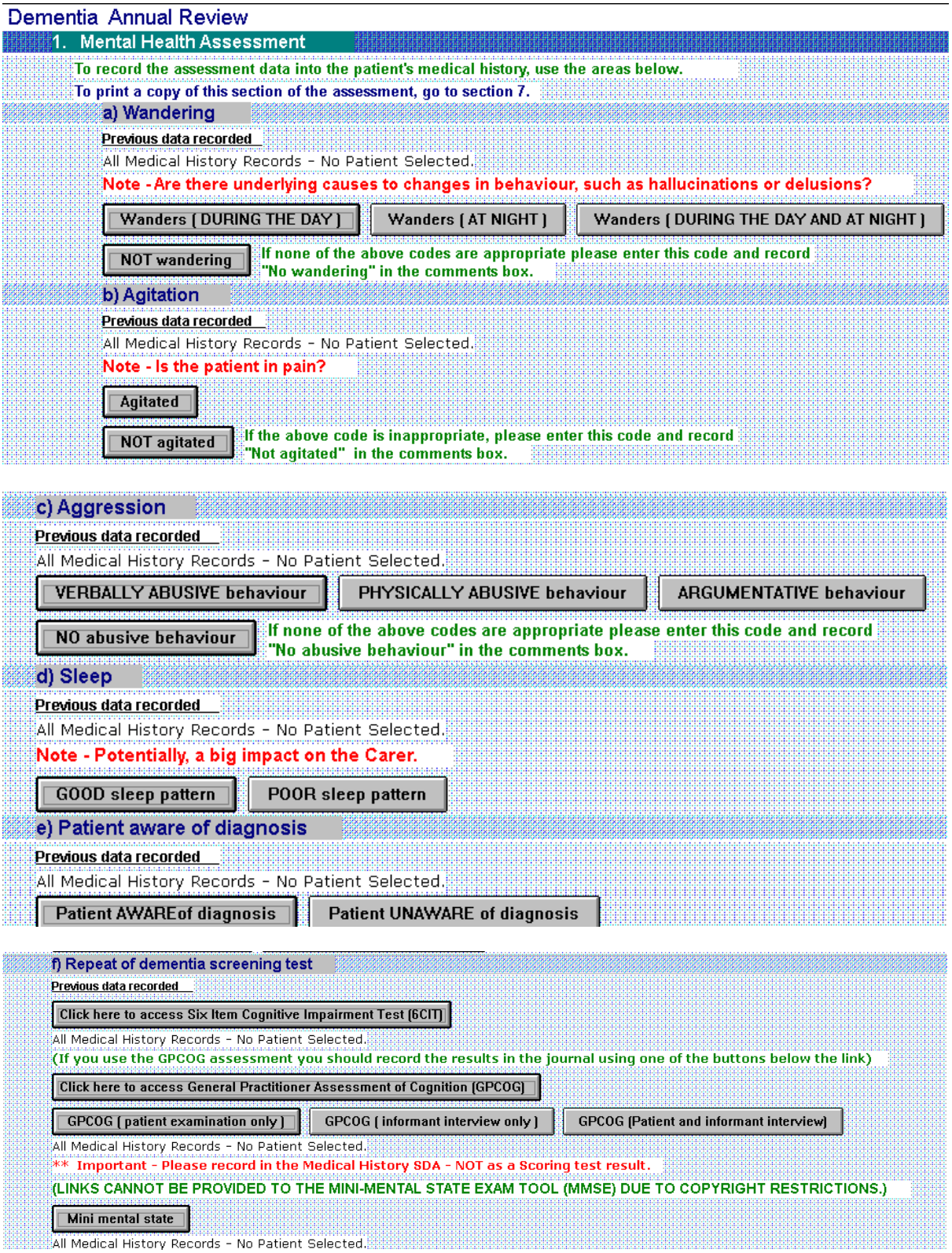
NHS Bolton Dementia Template for GP Practices

Screenshot



g) Depression screening

Previous data recorded

All Medical History Records - No Patient Selected.

Click here to access 4 item Geriatric Depression Scale (GDS-4)

Geriatric depression scale

** Please record results using this button

h) Fitness to drive

Previous data recorded

All Medical History Records - No Patient Selected.

Note - DVLA have to be notified of the diagnosis of dementia.

FIT - to drive | UNFIT - to drive

i) Financial Mismanagement

Previous data recorded

All Medical History Records - No Patient Selected.

All Medical History Records - No Patient Selected.

ABLE to manage financial activities | AT RISK of financial mismanagement

Power of Attorney - HELD | Power of Attorney - APPLIED FOR

j) Vulnerability assessment

Previous data recorded

All Medical History Records - No Patient Selected.

All Medical History Records - No Patient Selected.

At risk of PHYSICAL ABUSE | At risk of NEGLECT BY OTHERS | At risk of PSYCHOLOGICAL ABUSE

VULNERABLE adult | Vulnerable ELDERLY PERSON

k) Mental Health Assessment completed

Previous data recorded

All Medical History Records - No Patient Selected.

Ensure you click below to record completion of Mental Health Assessment

Mental Health Assessment COMPLETED

2. Physical Health Assessment

To record the assessment data into the patient's medical history, use the areas below.

To print a copy of this section of the assessment, go to section 7.

a) Appetite

Previous data recorded

All Medical History Records - No Patient Selected.

Appetite - NORMAL | Appetite - INCREASED | Appetite - REDUCED

b) Hearing

Previous data recorded

All Medical History Records - No Patient Selected.

Hearing - NORMAL | Hearing - DETERIORATING

c) Vision

Previous data recorded

All Medical History Records - No Patient Selected.

Vision - NORMAL | Vision - DETERIORATING | PARTIALLY Sighted | Registered BLIND

d) Mobility

Previous data recorded

All Medical History Records - No Patient Selected.

Mobility - FULL | Mobile - OUTSIDE WITH AID | Mobile - IN HOME | CONFINED to chair | BEDRIDDEN

e) Urinary continence

Previous data recorded

All Medical History Records - No Patient Selected.

Bladder - FULLY CONTINENT | Bladder - OCCASIONAL ACCIDENT | Bladder - INCONTINENT

FREQUENCY of micturition | NOCTURIA

f) Faecal continence

Previous data recorded

All Medical History Records - No Patient Selected.

Bowels - FULLY CONTINENT | Bowels - OCCASIONAL ACCIDENT | Bowels - INCONTINENT

g) Weight / BP

Previous data recorded

Last 3 Weight Records - No Patient Selected.
Last 3 Blood pressure Records - No Patient Selected.
Last 3 Medical History Records Where READ_CODE = "16D2.00 " - No Patient Selected.

Weight | Blood pressure

h) Self care / Risk of falls or accidents

Able to perform personal care activity | Unable to perform personal care activity

Does not fall | At risk of accident at home | Number of falls in last year

i) Physical Health Assessment completed

Click below to record completion of Physical Health Assessment

Physical Health Assessment completed

Last 1 All other Clinical Data Records Where READ_CODE = "38C2.00 " - No Patient Selected.

Medication Review

To print a copy of this section of the assessment, go to section 7.

Last 3 Repeat Medication Review Records - No Patient Selected.

1. **If the words above state "No data recorded" you will need to add a NEW medication review. (You can use the button below)**
2. **If a past review IS detailed above, DO NOT use the button below, go to the THERAPY tab to update the review.**

ALWAYS update existing reviews rather than setting up new ones .....

Consider the following:	
Use of dementia specific medication	Anti-cholinesterase inhibitors? Memantine?
Use of anti-psychotics	Can the use of anti-psychotics be avoided?
Use of anti-depressants	Is there a need for anti-depressants?
Use of sedatives	Can the use of sedatives be avoided?

All Repeat Masters Records - No Patient Selected.

Add new medication review

4. Impact on Carer / Carer's Needs

To record the data directly into the patient's medical history, use the areas below.
To print a copy of this section of the assessment, go to section 7.

a) Carer information

Previous data recorded

Carer's DETAILS | NAME of carer | Carer - HOME PHONE NUMBER | Carer - MOBILE PHONE NUMBER

All All other Clinical Data Records - No Patient Selected.

b) Relationship to patient

Previous data recorded

PARTNER is informal carer | RELATIVE is informal carer | FRIEND is informal carer

All All other Clinical Data Records - No Patient Selected.

c) Proximity to carer

Previous data recorded

Living WITH CARER | Carer LIVES NEARBY | Carer LIVES AT A DISTANCE

All All other Clinical Data Records - No Patient Selected.

e) Additional information

Previous data recorded

Carer ABLE to cope | Carer UNABLE to cope | Carer's assessment of needs

All All other Clinical Data Records - No Patient Selected.

5. Communication with / Referral to other services

To record the assessment data into the patient's medical history, use the areas below.
To print a copy of this section of the assessment, go to section 7.

Previous data recorded

Care co-ordinator

Memory Assessment Team

REFER to Memory Assessment team | SEEN IN Memory Clinic

Social Services

REFER to Social Services | SEEN BY Social Services | REPORT RECEIVED from Social Services

Voluntary Services

REFER to voluntary service | RECEIVES HELP from voluntary agency

District Nurse

REFER to District Nurse | DISTRICT NURSE attends

Intermediate Care

REFER to Intermediate Care

Care plan in place

Vulnerable Adult Care Plan | Agreement of care plan

6. Dementia Review Completed

Click below to record completion of Dementia Review

Dementia Review completed

To close guideline, click shutter icon next to question mark icon & return to QOF Dementia guideline

7. Paper copies of assessments (for printing)

Documents have been created to assist with this assessment and can be used in a face to face environment or printed and given to a carer for their completion.
The data will then need to be entered into Vision (using buttons in the relevant sections).

For "technical" reasons, do not complete these forms directly on the computer.
They are designed to be printed off and completed manually.

Click here to access "MENTAL HEALTH ASSESSMENT" questions
Click here to access "PHYSICAL HEALTH ASSESSMENT" questions
Click here to access "MEDICATION REVIEW" questions
Click here to access "IMPACT ON CARER / CARER'S NEEDS" questions
Click here to access "COMMUNICATION WITH OTHER SERVICES"