SWARG ADMISSION GUIDELINE 2017

RESIDENT NAME:-
DATE OF ADMISSION:
DATE OF BIRTH:
TIME OF ADMISSION:
ADDRESS:
MOBILE:
LANDLINE NUMBER:
E-MAIL:

SWARG™
COMMUNITY CARE
Connecting People, Enriching Health

SWARG COMMUNITY CARE
WWW.SWARGCOMMUNITYCARE.ORG | 85 11 66 66 64

PART A – RESIDENT'S BASIC INFORMATION

Are you applying for?

- ☐ Rehabilitation Care Division
- ☐ Short term care
- ☐ Long term care
- ☐ Permanent Entry

1. Resident's Details

If applicable, please write your name exactly as shown on your ID card.

Title (Mr., Mrs., Miss etc.)	
Last Name	
First Name	
Preferred Name	
Gender	☐ Male ☐ Female
Marital Status	Age
Home Address	
	Postcode
Contact Numbers	
Language that you speak	
Blood Group	

2. Sponsor's/Family Member's Details

Title (Mr., Mrs., Miss etc.)	
Last Name	
First Name	
Gender	☐ Male ☐ Female

Relation with Resident	
Occupation	
Postal Address	
	Postcode

Contact Numbers	Telephone:
	Mobile:
	E-mail Address:

If this person has the legal authority to make decision for you, please advise the kind of authority that you have (e.g. Power of Attorney).

3. Secondary Family Member/Guardian Details

Title (Mr., Mrs., Miss etc.)	
Last Name	
First Name	
Gender	☐ Male ☐ Female
Relation with Resident	
Occupation	
Postal Address	
	Postcode

Contact Numbers	Telephone:
	Mobile:
	E-mail Address:

4. Emergency Contact Detail

Name	
Contact Numbers	Telephone:
	Mobile:
	E-mail Address:

5. Responsibility of paying accounts and correspondence

Name	
Occupation	
Postal Address	
	Postcode
Contact Numbers	Telephone:
	Mobile:
	E-mail Address:

6. Please advise whether there are any cultural, religious or other specific requirements that you have before admission in Swarg Community Care (SCC).

7. Spouse/Partner Information

Are you and your spouse/partner applying together for a place in SCC facility?

☐ YES ☐ NO ☐ NOT APPLICABLE

If so, complete the following details:

Spouse/Partner Name:	
Address	
	Postcode

8. Details of Family Doctors

Name:	Speciality:
Address:	
Contact Number:	

9. Emergency Time Hospitals Refer

PART B – CARE ASSESSMENT DETAILS

Medical Report

(To be completed by Medical Practitioner – GP / Hospital / Doctor etc.)

i) Diagnosis

ii) List of Medical Conditions *(Tick where applicable)*

Asthma	❑ Yes	Tuberculosis (PTB)	❑ Yes
COLD	❑ Yes	Malignant Disease (specify):	❑ Yes
CCF	❑ Yes	_____	
IHD	❑ Yes		
Hypertension	❑ Yes	MRSA – colonized / infective	❑ Yes
High Lipid/ Cholesterol	❑ Yes	Infectious Disease	❑ Yes
Stroke/ CVA	❑ Yes	HIV	❑ Yes
Diabetes Mellitus	❑ Yes	History of Leprosy	❑ Yes
Amputation (BKA/ AKA)	❑ Yes	Dementia (specify)**_____	❑ Yes
Fracture (of major bone/ joint)	❑ Yes	Depression	❑ Yes
Parkinson's Disease / Parkinsonism	❑ Yes	Psychiatric Problems**_____	❑ Yes
Gastric Problems	❑ Yes	Mentally Retardation / Intellectually Disabled	❑ Yes
History of Alcoholism	❑ Yes	Comatose / Semi-conscious	❑ Yes
History of Smoking	❑ Yes	Others (specify): _____	❑ Yes
Epilepsy	❑ Yes		

iii) Surgical History (if any)

iv) Any History of Drug Allergy?

	❑ No	❑ Yes, specify:

v) Sensory Function

Speech	❑ Satisfactory	❑ Slurred	❑ Aphasic
Hearing	❑ Satisfactory	❑ Partial deafness	❑ Total deafness
Vision	❑ Satisfactory	❑ Partially impaired	❑ Total blindness

vi) Investigations, Significant Laboratory Results / Radiology (i.e., Chest X-Ray) / Scan Findings:

❑ Chest X-Ray Results:_____ Date Taken: _____

❑ Blood Test Results:

❑ MRI/CT scan Impression:

Medical Report

(To be completed by Medical Practitioner – GP / Hospital / Doctor etc.)

vii) Resident requires the following Nursing Care / Procedures (*please tick where appropriate*) :

Respiratory	**Nutritional and Gastro-Intestinal**	**Urinary Tract**	**Wound Care**
❑ Oxygen Therapy	❑ NG / Ryle's Tube Feeding	❑ Intermittent Catheterization, Fq_____	❑ Sites _____
❑ Tracheotomy Care	❑ PEG	❑ Indwelling Urinary Catheter	❑ Stage _____
❑ Biped Machine	❑ Colostomy	❑ Not Applicable	❑ Sizes _____
❑ Not Applicable	❑ LIeostomy		❑ Not Applicable
	❑ Special Diet Therapy (specify)_____		
	❑ Not Applicable		

viii) Management Plan / Treatment Regime

Follow Up at GP/ Hospital?

❑ No	❑ Yes		
	Centre / Hospital:	Name of Doctor	Date / Time

Name Medical Practitioner completing this Report:	
Designation: **Telephone/Mobile:**	
Signature:	
Date:	

PART C – ACTIVITY OF DAILY LIVINGS (ADLs)

Activity Of Daily Living (ADLs) (To be completed by Medical Practitioner)				
Name of Resident:			**BED NO:**	
Rating	**A**	**B**	**C**	**D**
Q1 Mobility	Independent	Requires some Assistance (physical/assistive device)	Requires frequent assistance/ turning in bed	Requires total physical assistance
Q2 Feeding	Independent	Requires some Assistance	Requires total Assistance	Tube-feeding
Q3 Toileting	Independent	Requires some physical assistance	Requires commodes / bedpans / urinals	Incontinent and totally dependent
Q4 Personal Grooming & Hygiene	Requires no assistance	Requires assistance for some activities/ supervision	Requires assistance for all activities	Bed/ trolley bathing
Q5 Treatment	Daily Medication Oral/Topical : 1 pt	Daily Medication Oral/Topical : 1 pt Injection: 2 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts Sp*procedures @1 pt/ 5 min
Q6 Social & Emotional Needs	Nil	Occasionally	Often	Always
Q7 Confusion ▪ loses way ▪ loses things ▪ disorientated	Nil	Occasionally (1-3 times a week)	Often (4-6 times a week)	Always (Daily)
Q8 Psychiatric Problems ▪ hallucination ▪ delusions ▪ anxiety ▪ depression	Nil	Mild Interference in Life	Moderate Interference in Life	Severe Interference in Life
Q9 Behavior Problem ▪ restless ▪ disruptive ▪ absconds ▪ uncooperative	Nil	Occasionally (1-3 times a week)	Often (4-6 times a week)	Always (Daily)
Total Points		**Category** 1 2 3 4 *(Circle)*		

Cat 1	≤6 pts	**Cat 2**	7 – 24 pts	**Cat 3**	25 – 48 pts	**Cat 4**	≥49 pts

PART D – PHYSIOTHERAPY ASSESSEMENT FORM

HISTORY

MUSKULOSKELETAL EXAMINATION

- Pain
  Onset:_____
  Type: _____
  Intensity: _____
- Spasm:_____
- Tenderness:_____
- ROM:
- Muscle Power:
- Deformity:_____
- Posture & Gait:_____

NEUROMUSCULAR EXAMINATION

- Higher Mental Function:
  Attention: _____
  Memory: _____
- Motor Function:
  Tone: _____
  Deep Tendon Reflexes:
  _____
  _____

Voluntary Control Grading:

_____

_____

- Sensation
  Superficial: _____
  Deep: _____

RESPIRTORY EXAMINATION

- Rhythm:_____
- Cough Strength: _____
- On Auscultation: _____

CIRCULATORY EXAMINATION

- Peripheral Pulses: □ Compatible □ Not Compatible
- Edema:_____
- Any wound/Bedsore: _____

FUNCTIONAL STATUS

□ Dependent
□ Partial Independent
□ Independent

Name of Physiotherapist: _____

Assessment Completion Date: _____

Signature: _____

PART D – MEDICATION ADMINISTRATION RECORD

Medication Administration (To be completed by attending Pharmacist or if any)			
SR.NO	**MEDICATION**	**DOSAGE**	**TIME**

PART E – DECLARATION AND CONSENTS

1. I/We declare that the information in admission form is complete and correct. I/We also understand that giving false or misleading information is a serious offence.
2. **Price is inclusive of** (a) Room charge (b) Nursing care & Attendants (c) Food (d) Physiotherapy (e) Weekly GP doctor's visit.
3. **Price does not include** (a) Medicines (b) Surgical Tools e.g., urine bags, catheter, Ryle's tube, diapers, any dressing materials, etc. (c) Lab test and diabetes test (e) Specialist doctor's visit (f) Special diet (g) Special or personal or additional staff (h) Hair dressing (i) Laundry care – 200 Rs.
4. **Medication:** Swarg staff is only responsible to deliver timely medicines to the resident. Family member will be a part of the decision making process but they cannot give direct care or medications. Included changing or discontinuation of medications or the switch to generic medications as the facility sees fit without concern with Manager or Coordinator.
5. Smoking, Alcohol, Gutakha, spitting, yelling or abusing staff or others by resident or their family member is not tolerable in the facility.
6. TV, phone or any communication device, roaming in premise is not allowing before 7 a.m. and after 10 p.m. Swarg is having telephone service only in case of emergency, personal outgoing calls are not allow.
7. **Food:** Only food items prepared in the facility's kitchens/Canteen of SCC may be consumed in these areas. Food from home or outside vendors must not be brought directly to resident rooms. Such food from home or outside vendors may not be served or eaten by the residents.
8. **Visiting Hours:** It is strictly prohibited the visit, except the visiting timing **i.e. 4 p.m. to 6 p.m.** with **minimum 2 guardians**. Exceptional circumstance, need prior permission of supervisor.
9. **Refund Payment Policy:**
    - Once payment has been made, there is no circumstance for refund.
    - No refund in case of daily, monthly and 3 months services would be considered.
    - For 6 or 12 months of service, refund will be provided if service is terminate or death within 2 months. If early discharge or death occurred after 2 months, no refund will be provided.
    - Once payment date cycle has been started and required discharge or death occurs, you need to pay full month payment or if payment has been made, no refund will be provided.
10. **Belongings:** Service user need to bring their own **towel, blankets** and **personal items** due to hygiene issues.
11. **End of Life Care:** After confirmation of death, Swarg will inform to family member immediately. The cause of death certificate will provide by Swarg management.
12. SCC is facilitated to accommodate **terminally ill** or aged person. **Family should not expect a treatment for the service user rather they should expect only care at SCC**. **The service user may pass away due to his/her terminal illness or concerns for which SCC would not be liable**.
13. **Emergency Hospitalization Process:** In case of emergency, staff will try to contact the guardian to get their verbal consent/decision. In case the staff may not able to get in touch with the guardian or the family members for some reason, the final decision would be taken by the Manager or Coordinator.
    - During or after hospitalization family member must have to be there for an admission process. Family member may not expect from Swarg to provide staff to stay nor does admission process for their loved one.

- Family member who lives in abroad, they must have to arrange someone who can help to do hospitalization process as hospital won't give an admission without family member concerns. No expectation from Swarg to pay hospital expenses on behalf of resident. It should pay separately than monthly care fees. As per hospital rules, some amount of deposit need to be paid during an admission. Family member must have to pay deposit in advance before hospitalization process.

14. If Family Member would like to discontinue Swarg services, they must have to inform to office 7 days before due date of bill cycle. Failure to do so, 7 days charges will be applied.
15. Swarg has rights to transfer bed or room location, depending on their mobility requirements.
16. **Monthly charges should be paid within 5 days of due date of service**. If payment is not received within 5 days of due date then 1st reminding letter or message will be sent. If payment is unpaid for 15 days then 2nd warning letter or message send. **If remains unpaid for 1 month, Swarg has rights to send resident back home or take a legal action.**
17. **Cheque payment: Penalty (500 rs.) will be applied if cheque will bounce. If cheque continues bounce then legal action can be taken.**
18. **Advance bed booking fees only valid for 1 month. After month fee is not refundable.**
19. **Discharge Process:** Once service user will discharge from Swarg facility, Swarg is not responsible for any circumstance of service user. Discharge certificate will not be issued if remains payment
20. Swarg is very stick about valuable items. Please do not bring your valuable items such as jewelleries, mobile phone, laptop, camera and money. Swarg is not responsible if any items will misplace from facility.
21. **For Mentally ill or retarded Resident**:
    - Swarg can take care of this resident if they are not harmful to others. However if resident will attend any disorder like run away without intimation, to attend suicide or become violent or hitting others, Swarg has rights to give early discharge and no expectation for refund payment.
    - After give intimation to family, if they won't arrive on immediate basis, Swarg has rights to send service user back home on provided address or take a legal action or immediate inform to police station. We are not responsible for service user after it.
    - If mentally ill resident or other service user will damage any Swarg property, family member have to pay that expenses.
22. During stay at Swarg if any resident required additional facility like air-condition, extra fan, air cooler, TV or any other, family member must have to organize for him/her.
23. I do give permission for photographs to be taken and used for the purpose of reflecting Swarg Community Care services in a positive light. Also I don't have objection if organization will use my loved one's photo for marketing purpose**.** □ **YES** □ **NO**
24. □ **Yes,** I am giving permission to Swarg to purchase required items for my loved one on behalf of me like

    □ Surgical items e.g. diapers, catheter bag etc.
    □ Daily required & prescribed Medicines
    □ Personal Care Items e.g. soap, hair oil, talc power etc.

    I will reimburse all paid amount by SCC in the end of the monthly bill cycle along with monthly payment. All purchase bills will be provided if guardian will needed.

□ **No,** I am going to purchase all required items like surgical tools e.g. diapers, catheter bag etc., medicines, personal care items e.g. soap, hair oil for my loved one and will deliver to him/her whenever it will be needed.

I/We fully understand all above mentioned concern points and will follow the same, while using Swarg Services.

<table>
<tr><td>PRIMARY GUARDIAN NAME</td><td rowspan="2">PHOTO</td></tr>
<tr><td>PRIMARY GUARDIAN SIGN</td></tr>
<tr><td>SECONDARY GUARDIAN NAME</td><td rowspan="2">PHOTO</td></tr>
<tr><td>SECONDARY GUARDIAN SIGN</td></tr>
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SWARG AUTHORISED NAME SIGNATURE

Agreement signed date: _____