RAILWAY CONVALESCENT HOME APPLICATION FORM
Bridge House, Dawlish

Mrs/Miss/Mr…………………………….………….

Address…………………………………………….

……………………………………………………

Post Code …………………………………………

Tel No ……………………………………………..

Occupation ……………………………………………

Employer………………………………………………

Address………………………………………………..

……………………………………………..……………..

Post Code ……………………………………………

Please indicate thelength of stay required : 1 or 2 weeks? ❑

Emergency contact name, relationship to you & tel no…………………………………………………………

You will be admitted at the first available date. Please state any dates which are NOT convenient due to hospital appointments etc. …………………………………………………………

Do you wish to bring a companion for all or part of your stay ? …………..(Please note you will be responsible for payment for the additional person.)

The Convalescent Home is owned and administered by the Railway Convalescence Homes, and they have kindly extended facilities to members of our Organisation. Their rules and regulations governing admission to the Home will, therefore, apply.

CONDITIONS OF ADMISSION

1. Patients taking prescriptions must ensure that they bring an adequate supply of medicines.
2. Diets can only be catered for if the Doctor's Medical Certificate is produced to this effect as the Centre does not have Diet Kitchens
3. It is unlikely that the limited number of single rooms will be available.
4. Patients are responsible for making their own travel arrangements to and from the Home.

Please complete the application form and ensure that the Medical Certificate is completed by a Qualified Medical Doctor, and **then return all admission documentation to your Regional Office** as soon as possible as admissions will not be arranged more than five weeks in advance.

BRANCH ………………………………………… REGIONAL SECRETARY …………………..……..…

MEMBERSHIP NO …………………………… DATE OF JOINING ……………………………………

AUTHORISED BY ……………………………………. BRANCH SECRETARY

PATIENTS DECLARATION

If accepted, I agree to abide by the current conditions of admission of patients at the RCH Convalescent Homes.

Signature of Applicant ……………………………………………. Date ……………………………………..

MEDICAL CERTIFICATE

The Centre is for patients in need of Convalescence following illness, injury or surgery. There is a resident Matron and a local GP visits weekly. There is no nursing assistance, except in emergency.

I certify that ………………………………………………………………...……date of birth…………..………

has been under my care for…………...weeks OR was hospitalised from …………………….……………...…

Nature of illness/Operation (if depression/anxiety neurosis please state principal cause)

……………………………………………………………………………………………….………………

Other Medical Conditions…………………………………………………………………….…………………

Possible date when member can return to work……………………………………………………………….

TREATMENT INFORMATION

Is the patient having injections ?	YES ❑	NO ❑	Self – administered ?	YES ❑	NO ❑
Is a dressing needed ?	YES ❑	NO ❑	Can patient manage this unaided ?	YES ❑	NO ❑
Is patient on a special diet ?	YES ❑	NO ❑	Details should be attached		

Drugs being taken by the patient (BLOCK CAPITALS)

…….

…….

IS THE PATIENT

In need of convalescence, now, to aid recovery?	YES ❑	NO ❑
Fit enough to travel safely to the Centre unaccompanied and without any adverse effect on recovery ?	YES ❑	NO ❑
Free of any risk of infection to others, mentally stable, stabilsed if epileptic?	YES ❑	NO ❑
Continent and capable of attending to personal needs without assistance?	YES ❑	NO ❑
Able, without lifts or assistance to get up and down stairs?	YES ❑	NO ❑
Can patient walk unaided ?	YES ❑	NO ❑

The above patient was seen by me on ………………………and in my opinion is a suitable patient for convalescence.

Doctor's signature……………………………………… Address of Practice…………………………………….

Doctor's Name………………………………………….. ………….……………………………
(CAPITALS)

………….……………………………

Date……………………………………………………