Saint John of God Kerry Services
Person Centred Plan

Section 1 General Information

Surname: _____
Forename: _____
Name which person prefers: _____
Gender: Male _____ Female _____
Date of Birth: _____
Religion: _____
Next of Kin: _____
Address: _____
Relationship: _____
Tel No: Home _____ Mobile: _____
Other Contact
Name: _____
Address: _____
_____
Relationship: _____
Tel No: Home _____ Mobile: _____

Medical Emergency Information _____
_____
_____
_____
_____
DNR Status: _____
Diagnosis: _____
_____
_____
Do You Have Known Allergies? Yes / No
If Yes List Cause and Reaction
_____
_____
_____
Date Of Admission: _____
Medical Card No: _____
Hospital No: _____
PPS No: _____

Baseline Observations

Weight: 	Temperature; Pulse;	Smoker: Yes/No 	Drink Alcohol: Yes/No 
Height:  Build	BP: Respirations:	Number of cigs per day?	Units per week?
Body mass index (Appendix 1)	**Eye Colour**	**Skin Type**	**Hair**

Do You Have any of the following Conditions

Diabetes	**Epilepsy**	**Respiratory Conditions**	**Cardiac**	**Coeliac**
Management Plan Yes No	**Management Plan Yes No**	**Details**	**Details**	**Details**

Assessment Date & Signature _____Year 1 Review Date & Signature _____Year 2 Review Date & Signature_____

Section 5

Annual Summary Evaluation **Name of Service User:** _____

Health:

	Date	Reasons for Visits/ Duration of hospital stay	List any Significant Tests carried out/Treatments/recommendations from visits e.g. Medication changes, New Diagnosis, other
General Practitioner:			

Summary Evaluation Completed By: _____ Signature & Date: _____

Section 5

Annual Summary Evaluation **Name of Service User:** _____

Health:	**No. Of Visits in Last 12 months**	**Reasons for Visits / Duration of hospital Stay**	**List any Significant Tests carried out/Treatments/recommendations from visits e.g. Medication changes, New Diagnosis, other**
Dental:			
Optician:			
Ophthalmologist:			
Psychology/Behaviour Specialist			
MEBs Plan in Place	**Yes/ No**	**PSR Scored Yes / NO**	**Date Last PSR Scored / / PSR Score**
Dietician			

Summary Evaluation Completed By: _____ Signature & Date: _____

Section 5

Annual Summary Evaluation **Name of Service User:** _____

Health:

	No. of Visits In Last 12 months	**Reasons for Visits/ Duration of hospital Stay**	**List any Significant Tests carried out/Treatments/recommendations from visits e.g. Medication changes, New Diagnosis, other**	
Social Work:				
Other: (Please Specify)				
Family Contact	**No Home Visits**	**No. Day Visits**	**List other Types of Contact e.g. Phone, Skype, Cards,**	**Support Provided e.g. transport, Remain at home visit, set up Skype, maintain pictures, albums, send cards**
Personal Outcomes Planning Meeting Complete	**Yes /No**	**Date of Last Planning Meeting** / /	**Minimum six monthly reviews in place Yes / No**	**Action Required**

Summary Evaluation Completed By: _____ Signature & Date: _____

Section 5

Health Action Plan **Name of Service User:** _____

Goal No.	Identified Goal	Action	By when	Signature	Outcome: Annual Summary Review of Goal	Signature