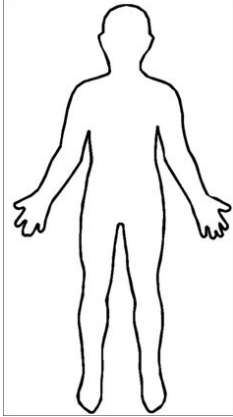
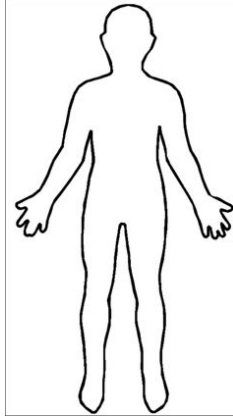


Do you have any skin pressure risks?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please complete Braden Scale.			
Have you had any falls in the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please complete Falls Risk Assessment.			
Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Site 1	Site 2	Front	Rear
			
Severity:	Severity:		
Intervention:	Intervention:		
Cognition:	<input type="checkbox"/> Nil Issues	Other:	
Mental Health:	<input type="checkbox"/> Nil Issues	Other:	
Chemist:			
Allergies (document allergy and reaction):			
CURRENT MEDICATIONS			
Medication	Dose/Frequency	Route	Indication
Lifestyle:			
Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Daily Intake:
Do you smoke?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ceased: / /
Other Issues, e.g. Functional ADL's:			
Referrals Required:		<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
DECLARATION			
Name:		Designation:	
Signature:		Date:	