Sunrise Village Tuncurry
A safe haven for now and the future...

Sunrise Supported Living
All we do is Care

Goals

What you would like to achieve in your daily life:	How Sunrise can help you to do this...

Social and Medical History

Are there any social or medical issues that will impact your goals?

Current Care Help

Do you currently have a Home Care Package?

☐ No ☐ Yes

If yes, what level?

Do you currently receive these services at Home?

☐ Personal care
☐ Nursing care
☐ Respite care

Do you currently receive other services at Home?
(E.g. Housework, gardening meals)

☐ No ☐ Yes

If yes, list here

Do you have a carer?

☐ No ☐ Yes

If yes, list here

Do you have family members or friends who visit and help you?

☐ No ☐ Yes

If yes, list here

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Activities of Daily Life

Do you have difficult with your vision? If so, do you wear glasses and are you currently using eye drops?

☐ No ☐ Yes

Comment:

Do you have difficult with hearing? If so, do you wear hearing aids?

☐ No ☐ Yes

Comment:

Do you need assistant Showering?

☐ No ☐ Yes

Comment:

Do you have any bathing aids you will be bring into Sunrise or do you need us to arrange aids?

☐ No ☐ Yes

Comment:

Nutrition

Will you be going on a meal plan?

☐ No ☐ Yes

☐ Lunch ☐ Dinner ☐ Both

Comment:

Do you have any food requirements?

☐ No ☐ Yes

Comment:

Have you noticed you have recently lost weight or having a poor appetite?

☐ No ☐ Yes

Comment:

More about you

Are you concerned about your memory?

☐ No ☐ Yes

Comment:

Do you suffer anxiety or depression?

☐ No ☐ Yes

Comment:

Understandably, moving & change of lifestyle can be challenging. Are you coping with your current situation?

☐ No ☐ Yes

Comment:

Is there anything else you would like us to know about you?

☐ No ☐ Yes

Comment:

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Mobility

Do you have any previous injuries or current illness' which affects your mobility?

☐ No ☐ Yes

Comment:

Do you currently use a walking aid or any other aids for mobility?

☐ No ☐ Yes

Comment:

Have you seen a specialist or physiotherapist regarding your mobility?

☐ No ☐ Yes

Comment:

Continence

Do you have any urine or Bowel incontinence or concerns? (this can include constipation/Diarrhea)

☐ No ☐ Yes

Comment:

Pain & discomfort

Do you suffer any pain?

☐ No ☐ Yes

Comment:

Do you take any medication to relieve pain?

☐ No ☐ Yes

Comment:

Sleep & rest

Do you suffer any sleeping disorder? E.g. Insomnia

☐ No ☐ Yes

Comment:

Medication

Do you need assistance with monitoring your medication?

☐ No ☐ Yes

Comment:

Are you allergic to any medication? ☐ No ☐ Yes

If so, which:

Is your medication deposited in a Webster pack

☐ No ☐ Yes

Do you have a preferred Pharmacy? ☐ No ☐ Yes

Which one:

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Skin integrity

Do you have a regular skin regime?

☐ No ☐ Yes

Comment:

Do you have any current wounds we should know about?

☐ No ☐ Yes

Comment:

Risk Assessment

Do you smoke?
Reminder: No smoking is allowed inside Villas

☐ No ☐ Yes

Comment:

Do you drink alcohol?

☐ No ☐ Yes

Comment:

Do you have pets?
Reminder: Please complete our Pet Policy form

☐ No ☐ Yes

Comment:

Have you had a fall?

☐ No ☐ Yes

Comment:

Safety Requirement

Do you require assistance shopping?

☐ No ☐ Yes

Comment:

Do you require transport to appointments?

☐ No ☐ Yes

Comment:

Care preference – what areas do you feel you need current help with?

Comment:

On-going Plan

Residents request:	Sunrise Intervention:

Additional services

Do you require internet connection? ☐ No ☐ Yes
Note: Additional charges may apply

Do you require the telephone? ☐ No ☐ Yes
Note: Additional charges may apply

/ /

Clients signature **Date**

/ /

Assessor name **Date**

Refer to RN