

ABBOTSFORD CARE (GLENROTHES) LTD

Signs of Being Unwell

Resident Name:		Room Number:	
Known As:		Date of Birth:	

After looking at the maintaining psychological wellbeing check-in sheet or based on observations the following signs of ill-being have been noticed: ***please tick all relevant new symptoms.***

<input type="checkbox"/>  Increased temperature	<input type="checkbox"/>  New Cough	<input type="checkbox"/>  Mood Changes
<input type="checkbox"/>  Change in mobility	<input type="checkbox"/>  Increased Falls	<input type="checkbox"/>  Loss of muscle mass
<input type="checkbox"/>  Weight Loss	<input type="checkbox"/>  Reduced Appetite	<input type="checkbox"/>  Swallowing Problems
<input type="checkbox"/>  Continence Problems	<input type="checkbox"/>  Urinary Tract Infections	<input type="checkbox"/>  Constipation
<input type="checkbox"/>  Increased Confusion	<input type="checkbox"/>  Sleep Disturbance	<input type="checkbox"/>  Increased Pain

What actions have been taken as a result:

Date:		Signed:	
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