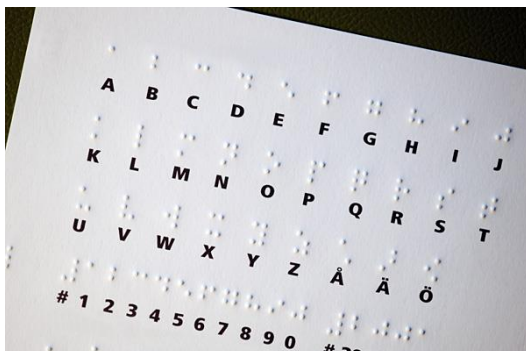
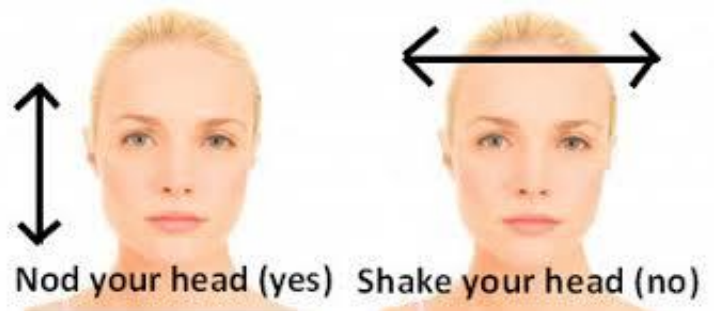
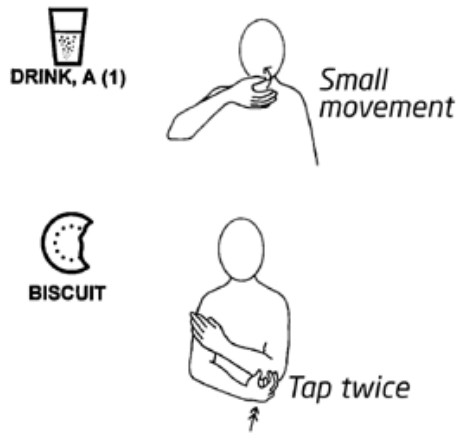
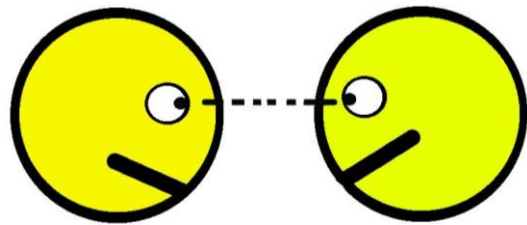




What is the name of someone who speaks on behalf of others?

Eye-Contact



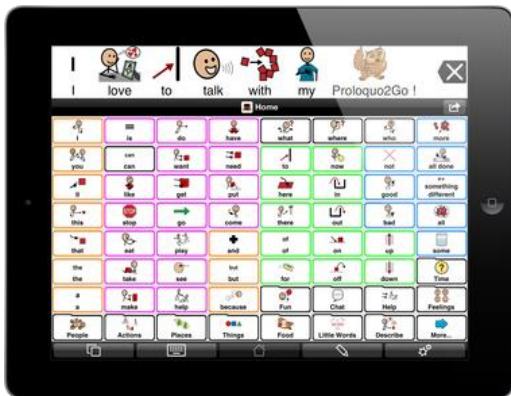
SHERBORNE SCHOOL		
UPPER SCHOOL	REPORT FOR TERM	
Form <i>Vith Group III</i>	Average Age	
Name <i>Dwight</i>	Age	SUMMER TERM, 1929.
DIVINITY		MASTER
PRINCIPAL SUBJECTS	<p><i>Chemistry</i>. He is ever trying to improve his style in written work, with good results.</p> <p><i>Mathematics</i>. His work on Higher Certificate papers shows distinct promise, but he must realize that ability to put a neat and tidy solution on paper - intelligible & legible - is necessary for a first-rate mathematician. He has done some good work but generally sets it down badly. He does not remember that Cambridge uses exact sound knowledge rather than vague ideas.</p>	<p>a.g.p.a.</p> <p>D.G.E.</p> <p>H.S.F.</p>



Telephone Message

To: _____
From: _____
Company: _____
Telephone no. _____ Ext. _____
 Please call Returned call Will call again
Message

Date _____ Time _____
Taken by _____
Level of Importance High Medium Low



Nursing Care Plan

CLIENT ID:
NAME:
D.O.B.:
DOCTOR:
PENSION:

RESIDENT'S:
CARE ALERT: FALLS RISK WANDERS BLIND DEAF CONFUSE

Diagnosis:

LIFESTYLE SUPPORT NEEDS	GOAL OF CARE	CARE OR INTERVENTION REQUIRED <i>Tick and/or Highlight Appropriate Response</i>
MEDICATION ADMINISTRATION Baseline Health Assessment <i>Self Administration Medication Management (11-03)</i> <i>Medication Assessment (11-59)</i>	RESIDENT MEDICATIONS ARE MANAGED SAFELY & CORRECTLY	Level of Assistance required: <input type="checkbox"/> Extensive prompting <input type="checkbox"/> Standing by to observe <input type="checkbox"/> Self administers medication <input type="checkbox"/> Staff administers medication <input type="checkbox"/> Refer to medication chart for specific instructions <input type="checkbox"/> Other
Notes		
PAIN MANAGEMENT <i>Elderly Mobility Scale (11-12)</i> <i>Self Administration Medication Management (11-03)</i> <i>Specific Needs Management Plan (11-22a)</i>	RESIDENT IS AS FREE AS POSSIBLE FROM PAIN	<input type="checkbox"/> Reposition <input type="checkbox"/> Massage <input type="checkbox"/> Analgesia <input type="checkbox"/> Heat packs <input type="checkbox"/> Aromatherapy <input type="checkbox"/> Relaxation Tapes <input type="checkbox"/> Supportive device eg. <input type="checkbox"/> One to one support/Diversion <input type="checkbox"/> Other <input type="checkbox"/> Refer to pain management program
Notes		
COMMUNICATION Links to Assessments: Baseline Health Assessment <i>Communication Assessment (11-04)</i>	RESIDENTS OPTIMAL LEVELS OF COMMUNICATION ARE MAINTAINED	VISION Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Wears always <input type="checkbox"/> Yes <input type="checkbox"/> No Reading only <input type="checkbox"/> Yes <input type="checkbox"/> No Magnifier <input type="checkbox"/> Yes <input type="checkbox"/> No Needs assistance with glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Refer to special nursing care needs <input type="checkbox"/> Yes <input type="checkbox"/> No SPEECH Difficulty with expressive communication <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty with receptive communication <input type="checkbox"/> Yes <input type="checkbox"/> No Is English the first language? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify: Non-verbal aids used <input type="checkbox"/> Yes <input type="checkbox"/> No Need help with communication aids <input type="checkbox"/> Yes <input type="checkbox"/> No Other
Name		Date
Signature		Designation

