****

Allocated to:

Start date/time:

Direct debit/Invoice

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| **Date Referral Taken:** |  | **Taken By:** |  | **Date/Time of Home Visit** |  |

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| --- | --- | --- | --- | --- | --- |
| **Name(s)** |  | **DOB:**  |  | **Age:** |  |
| **Gender:**  |  **Female / Male** |
| **Woman Man Transgender Non-binary/ Non-conforming Prefer not to say** |
| **Ethnicity:** |  |
| **What ethnicity are you?**  |  |
| **Address:** |   **Postcode:**  |
| **Phone number(s)** | **Landline:** | **Mobile:** |
| **Email Address:** |  |
| **Where did you hear about the service** |  |
| **Does anyone else live at the property?** |  |
| **Which Local Authority are you registered with?** |  |

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| **Type of Property:** |  |
| **Parking Details:** |  |
| **Access to Property:*****(how is the worker to access the property)*** |  |
| **Key safe Number & Location:** |  |
| **Lifeline & Provider:** |  |
| **Pets:** |  |
| **Smoker or Non-smoker:** |  |

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| --- | --- |
| **Referrer Name:** |  |
| **Relationship to Client:** |  |
| **Address:** |  |
| **Contact Details:** | **Phone:** | **Email:** |
| **Do you have consent from the individual to speak with us?**  | **Yes / No** |

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| **Services Required:****(Tick where appropriate)** | **General Support:** | **Housework:** | **Lifestyle:** |
| **Shopping:** | **Medication****Prompting:** | **Spring/Deep Clean:** |
| **Meal Preparation:** | **Escorting to Appointments:** | **Laundry/Ironing:** |
| **Other:** |
| **Physical health diagnosis or any disabilities.** **Any mobility aids used?** |  |
| **Mental Health Diagnosis:****Please list any addictions i.e. drugs, alcohol etc.****Any professionals involved? (name/profession if possible)** |  |
| **Security Concerns:****Does the referrer have any information on security issues in relation to the individual, the house or the area?** |  |
| **Safeguarding Concerns:****Does the referrer have any information about previous and/or current safeguarding history (violence/aggression/abuse/vulnerability/safety of staff etc?)****Is more than one person needed to visit?** |  |
| **DNAR/ Respect in place?****Where is it kept?** | Yes/No |
| **LPA (lasting Power of Attorney) Please ask the following questions.****Is there a LPA in place? Yes/No (please circle)****If yes:*** **Health and care – Yes/No**
* **Financial Decisions – Yes/No**
* **Both – Yes/No**
* **Who is the nominated person?**
* **Can we obtain the nominated person details as NOK?**

**Consent to liaise with NOK /LPA as and when necessary? Yes/No****Referrer:****If there is an LPA in place…*** **Have you seen the LPA document? Yes/No**
* **Is the nominated person one of the people nominated as NOK for the client?**
 | **Please ask for a copy to be available at the home visit if possible.****Notes:** |

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| **Other key people / organisations involved** |
| **GP Practice** |   | **Contact number:** |
| **Care Agency** |  | **Contact number:** |
| **Others** |  | **Contact number:** |

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| --- |
| **Emergency Contacts**  |
| **Name** | **Relationship**  | **Address** | **Contact details** |  |
|  |  |  |  |  |
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| **Are you happy for us to discuss your service with the above emergency contacts? Yes / No** |

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| **Referrals to other services** |
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| **Additional Information:** |
| **Allocation Suggestions:**  |

**Date …………………………………………………………………………..**

**Referrers Name:** …………………………………………………………. **Referrers Sign:** ……………………………………………………………………..