|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| A: PROSPECTIVE SERVICE USER | | | | | | | |
| Surname: |  | | First Name(s): |  | | Title: |  |
| Likes to be known as: |  | | Marital Status: |  | | DOB: |  |
| Age: |  |
| ADDRESS:  POST CODE: | | | | | NOK ADDRESS: | | |
| CONTACT NUMBER: | | | | | CONTACT NUMBER  MOBILE: | | |
| B: PRELIMINARY REQUIREMENTS FOR CARE | | | | | | | |
| Period of Day and Preferred Time | | | Duties required (please circle) | | | | No. of Carers |
| AM: | | M-S  M T W T F S S | Personal care meal prep medication. domestic | | | |  |
| LUNCH: | | M-S  M T W T F S S | Personal care meal prep medication. domestic | | | |  |
| TEA: | | M-S  M T W T F S S | Personal care meal prep medication. domestic | | | |  |
| BED: | | M-S  M T W T F S S | Personal care meal prep medication. | | | |  |
| C: FUNDING | | | | | | | |
| How is the P.O.C to be funded?  PRIVATE ICF IFS D/P PHB | | | | | | | |
| D: PERSON MAKING ENQUIRY | | | | | | | |
| Name: | | | | | | | |
| Address:  Tel No: | | | | | | | |
| Relationship to Prospective Service User: | | | | | | | |

Additional Information: (Risks identified, equipment in place, further assessments required.)

Medical Condition:

Mobility / Equipment: (history of falls)

Mental Health Status: (anxiety, depression, Dementia)

Personal Hygiene needs: (Washing & dressing etc)

Current Medication:

|  |  |
| --- | --- |
| E: PRIORITY RATING FOR CARE SERVICE | |
| Quote send: YES / NO | Quote Excepted: YES / NO |
| Emergency / Priority Referral: YES / NO | Date Assessment of Needs Conducted: |
| Preferred Date for Commencement of Service: asap | ACTUAL DATE for Commencement of Service: |
| WAITING LIST: YES / NO Review Date: | |
| F: INITIAL EQUIREY TAKEN BY | |
| Name:  Position:  Date: | |