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|  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 NUMBERMOBILE:  |
|  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:

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| 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:    |