**Telecare Service Referral Form**

*Please complete* ***all sections*** *unless indicated and send to***Telecare@calderdale.gov.uk**

**Someone will respond to you within 7-10 working days**

|  |  |
| --- | --- |
| **Person Details** | **Referrer Details****(Only required for non-self-referrals)** |
| Full Name: |  | Full Name: |  |
| Email: |  | Email: |  |
| D.O.B: |  | Referral Date: |  |
| CIS No: |  |
| NHS No: |  | Tel Number: |  |
| Home Address |  | Relationship to Client/Organisation: |  |
| Tel Number: |  | **Next of kin** |
| Key safe code: |  | Full Name: |  |
| Status of referral: | URGENT [ ] NON-URGENT [ ]  | Address: |  |
| Ethnicity: |  | Tel Number: |  |
| Religion:  |  | Email: |  |
| GP Details: |  |
| **Does the person have the mental capacity to make the decision to accept Telecare equipment?** [ ] Yes[ ] No If not have you completed a Mental Capacity Assessment [ ]  Yes ☐[ ]  No ☐[ ]  N/A |
| **Does the person require a language interpreter?** [ ]  Yes [ ]  No If yes, please give details:  |
| **Details of any specific communication needs:** Deaf, blind etc. |
| **IMPORTANT NOTE: The Lifeline cost is £8.65 per week; however, this is means tested.** |
| **Who is the telephone provider?** |  |
| **Does the person have a community alarm system in their home? (Care line linked to a monitor / responder service)** | [ ]  Yes [ ]  No  |
| **Person Group:** | Adult Elderly ☐[ ]  Mental Health ☐[ ] Physical Disability ☐[ ]  Learning Disability ☐[ ] Dementia / Memory support ☐[ ]  Falls Team ☐[ ]  |
| **Does the person live alone?** | [ ] Yes [ ]  No |
| **Other Occupant Details:**  |  |
| **Third Party contact details (to arrange visit):**  |  |
| **Reason for Telecare referral:** | [ ] Maintenance of independence[ ] Accident prevention[ ] Prevent admission to hospital [ ] Prevent admission to Nursing home/Residential care[ ] Prevent extended stay in hospital[ ] Prevent admission to emergency respite[ ] Prevent an increase in package of care[ ] Prevent increased demand on informal carer |
| **Does the person have any support or help at home?**For example, a family member who cares for you, paid carer, voluntary service |  |
| **Supporting Information****Please identify your concerns and equipment requested (if known)** |
|  |
| **Signed:**  | **Date:** |