**Telecare Service Referral Form**

*Please complete* ***all sections*** *unless indicated and send to*[**Telecare@calderdale.gov.uk**](mailto: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?** YesNo  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:** | | |