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|  | **Telecare Referral / Assessment** |
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| **USE OF INFORMATION SHARED**The information you give us will be held securely and in confidence. We may need to share this information with external health and social care professionals/providers who we may need to consult, in order to advise or provide you with the appropriate services. We may also use your information for service planning, monitoring services and research. Are you in agreement with this? **Yes** [ ]  **No** [ ]  |

 For further information please see the Telecare privacy statement [www.coventry.gov.uk](http://www.coventry.gov.uk)

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| **Has the person given consent for a referral for Telecare?** Yes [ ]  No [ ]  If the person is unable to give consent due to lack of capacity, who has acted in the person’s best interest? |
| Name: | Relationship to service user: | Date consent provided: |
| **Short Term Services to Maximise Independence (STSMI) pathway Yes [ ]  No** [ ]  |

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| 1. **Personal Details – all information is required**
 |
| Name |  | Client ID if on Care DirectorNHS No. |  |
| AddressInc. Postcode |  | Date of Birth |  |
| Landline Phone NoMobile E-mail Address |  | GP NameAddress Phone No. |  |
| Ethnicity |  | Religion |  |
| Next of KinRelationshipPhone NoMobileemail |  | Next of Kin Address |  |

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| **Medical conditions**

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| **Communication**  |

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| **Capacity to Respond - In the event of an alert being raised at the call centre, call staff will attempt to speak directly with the person through their telephone.** |
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|  | **Tick** | **If NO, how would you want the call centre staff to respond?** |
| Is the person usually able to communicate their needs verbally? | Yes [ ]  No [ ]  |  |
| Is English first language, if not please indicate what is | Yes [ ]  No [ ]  |  |
| Is the person visually impaired? | Yes [ ]  No [ ]  |  |
| Is the person hearing impaired | Yes [ ]  No [ ]  |  |
| Would the person be physically able to push or pull a trigger?  | Yes [ ]  No [ ]  |  |
| Would the person be cognitively able to push or pull a trigger? | Yes [ ]  No [ ]  |  |

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|  **Risks**  |

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| **E.g. Falls / Medication / Fire / Epilepsy / Continence / Flooding / Safety in the community****Please describe the issues / needs for which telecare is being considered****Equipment solutions - please enter any suggestions on required technology; this will be verified by the Telecare team** |

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| **Is a care package provided?** Yes [ ]  No [ ]  |
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| Name of Care Provider (if known): |
| Times of care package (if known) | Monday: |
| Tuesday:  | Wednesday: |
| Thursday:  | Friday: |
| Saturday: | Sunday: |

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| **Accommodation** |

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| **Does the person live alone? Yes [ ]  No [ ]** **Accommodation Type** |
| [ ] House [ ] Flat [ ] Bungalow [ ] Maisonette [ ] Static Home [ ] Other……………….  |
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| **Tenure** |
| [ ] Housing association [ ] Rented [ ] Owner [ ] Sheltered [ ] Other ….………….. |

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| **Name of housing association/supported housing** |
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| **Are there any potential risks in accessing the property?** E.g. animals, limited space, overgrown garden/unclear path to front door, limited parking/restricted parking, use of lift or stairs required  |
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| **Is there an active telephone line?**Telecare systems requiring links to the control centre cannot be fitted without a land line |
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[ ]  Yes - **Telephone Supplier** [ ]  No[ ]  N/A (if standalone equipment) |

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| **Is there a power socket within 2 metres of the phone socket (located on the same wall)?**If NO, the telecare team will contact you to discuss. |
| [ ]  Yes[ ]  No[ ]  N/A (if standalone equipment) |

**Does the person give consent for information to be passed to West Midlands Fire Service to undertake a Safe and Well check on the property?** Yes [ ]  No [ ]

**Emergency Contacts/ key holders**

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| Emergency contacts / Key holders must live within **30 minutes** travelling time of the service user. **All details must be completed**. |
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|  | **1st Contact****If this is NOK please record** **‘As NOK’** | **2nd Contact** |
| Key holder name |  |  |
| Relationship to service user |  |  |
| Key holder address |  |  |
| Key holder phone no. |  |  |
| Key holder mobile no. |  |  |

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**Please note: If the individual does not have two emergency contacts the responder service will be required. A keybox is essential for access to the property by the responder service.**

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| **Keybox**

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[ ]  Already in place Keybox No. if known [ ]  Already being ordered [ ]  Required **It is the responsibility of the referrer to complete the keybox referral.****Keyboxes are installed by The OPAL/ICES team.**If you do not have a copy of the keybox form please contact Telecare@coventry.gov.uk and one will be emailed to you. If the person resides in a Whitefriars property, please contact Whitefriars directly.A keybox cannot be fitted if the door has shared entry with other tenants e.g. in flats, unless all tenants have given written agreement to this and also agree to inform their home insurance company that a keybox has been installed.  |

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| **Installation -** Individual to be contacted to arrange the installation visit. Please provide name and daytime telephone number **If this is Service User or NOK please record as: ‘Service User’ or ‘NOK’** |
| Name:Telephone number:  |

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| **Objectives of Telecare – data required to assess the impact of Telecare** |

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| **If Telecare was not to be installed what could be the possible outcome?** |
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|  | **Tick** |  | **Tick** |
| Admission to Residential Care |  | Negative impact on informal carer/s |  |
| Additional Care Package at Home |  | Other - Please give details |  |
| Hospital Admission |  |  |  |

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| **Referral details** |

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| **Referred by:**  | **Job title:**  |
| **Contact number :** | **Emailaddress:**  |
| **Date of Referral:**  |  |

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| **Telecare Office Use only**  |

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| **Date referral received:** |  |
| **Telecare notes :** |

Please send the completed form to Telecare@Coventry.gov.uk