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|  | | **Telecare Referral / Assessment** | | |
| |  | | --- | | **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, 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)   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | **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** | | | | |  | | | | | |
| 1. **Personal Details – all information is required** | | | | |
| Name |  | | Client ID if on Care Director  NHS No. |  |
| Address  Inc. Postcode |  | | Date of Birth |  |
| Landline Phone No  Mobile  E-mail Address |  | | GP Name  Address  Phone No. |  |
| Ethnicity |  | | Religion |  |
| Next of Kin  Relationship  Phone No  Mobile  email |  | | 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.** |
| |  |  |  | | --- | --- | --- | |  | **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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| **Please describe the concerns / needs for which telecare is being considered**  **Please state the equipment you require – e.g. lifeline, door sensor etc**  **Please state urgency of referral and the reason why.** |

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| **Is a care package provided?** Yes  No |
| |  |  | | --- | --- | | 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 a power socket we can use for the telecare unit ?**  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**. |
| |  |  |  | | --- | --- | --- | |  | **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. |  |  | |

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

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| **Key box**   |  | | --- | |  |   Already in place Key box No. if known  Already being ordered  Required  **It is the responsibility of the referrer to complete the key box referral.**  **Key boxes are installed by the OPAL/ICES team.**  If you do not have a copy of the key box form, please contact [Telecare@coventry.gov.uk](mailto:Telecare@coventry.gov.uk) and one will be emailed to you. If the person resides in a Citizen property, please contact Citizen directly.  A key box 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 key box 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?** |
| |  |  |  |  | | --- | --- | --- | --- | |  | **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:** | **Email address:** |
| **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