



## Contact Self Assessment & Background Information

<b>1. Basic Personal Information</b>				<b>Confidential</b>
Surname			NHS no: Social Services no.	..... .....
First Names			N.I. no. Other Ref. No.	..... .....
Preferred Name			Permanent Home Address:	
Date of Birth		Title	Post code:	
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>			
Ethnic Origin	(see notes)			
Religion	(see notes)		Phone Number	
Preferred first language			Work Phone Number	
Interpreter Needed	YES/NO		Mobile Phone Number	
Advocate Needed	YES/NO		E-mail Address	
Current or Previous Occupation			Current or temporary address:	
Do you need help to see?	YES/NO		Postcode	Phone Number
Do you need help to hear?	YES/NO		Details of person acting on your behalf:	
Communication Aid Needed	YES/NO		Are they aware of the referral? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
If person being referred/you is/are unable to sign please state why:				

<b>2. Reason for Referral</b>		<b>Confidential</b>
What are the immediate reasons for this referral?	Name & Title of Referral Source:	
	Phone Number:	
	Date:	

Service user name:

ID number:

### 3. Services currently or previously being received

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What are the services you are **currently** receiving?

What are the services that you have received in the **past**?

Service User Category?  
(See notes on categories)

What if any long term disability or allergy do you have?

### 4. Key Contacts

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#### Person most close to you

#### Next of Kin (if different)

Family name:

Family name:

Forenames:

Forenames:

Relationship to you:

Relationship to you:

Address:

Address:

Post code:

Post code:

Phone number:

Phone number:

E-mail:

E-mail:

#### Main Informal Carer (if different)

#### Other Contact

Family name:

Family name:

Forenames:

Forenames:

Relationship to you:

Relationship to you:

Address:

Address:

Post code:

Post code:

Phone number:

Phone number:

E-mail:

E-mail:

#### GP Doctor

#### Dentist

Name:

Name:

Practice:

Practice:

Address:

Address:

Post code:

Post code:

Phone number:

Phone number:

Fax number:

Fax number:

E-mail:

E-mail:

Service user name:

ID number:

Hospital Consultant Contact	Other Professional involved
Name:	Name:
Ward Specialty:	Role:
Organisation:	Organisation:
Phone number:	Phone number:
Fax number:	Fax number:
E-mail:	E-mail:

**5. Home Details****Confidential****5a. Type of Accommodation**

Flat		If flat - What floor?		Warden controlled/sheltered	
Bungalow		Maisonette		Residential Home	
House		Nursing Home		Other	

**5b. Tenure of Accommodation**

Owner occupied		Private rented		Tied	
Housing Association		Local Authority		Other	

**5c. What Type of Heating do you have?**

Gas		Central Heating		Other Please specify	
Electricity		None			

**5d. Who lives in the House?**

Do you live alone?	YES	NO	Number of people in household
Do you have Dependents?	YES	NO	Who Lives with you?

**5e. Pets and Animals**

Are there any animals?	YES	NO	Is there anything we should know about them?
What animals do you have?			What arrangements have you made/are required in an emergency?

**5f. Key holder details and access****Please indicate how to get into your house**

Self  Key Safe  Entry System  Neighbour   
 Other  Please specify

Details of key holder:

Any other access details that we need to know about?

Service user name:

ID number:

## 6. Contact Assessment

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**6a. Describe in your own words the current difficulties that you are experiencing in your day-to-day life (presenting problem).**

<b>6b</b>	<b>Please tick your difficulties</b>	<b>Does anyone help you with these tasks?</b>	<b>How long have you had these difficulties? (if appropriate)</b>
<input type="checkbox"/>	Nothing	<input type="checkbox"/>	-----
<input type="checkbox"/>	Medicines	<input type="checkbox"/>	-----
<input type="checkbox"/>	Getting in and out of bed	<input type="checkbox"/>	-----
<input type="checkbox"/>	Washing	<input type="checkbox"/>	-----
<input type="checkbox"/>	Dressing	<input type="checkbox"/>	-----
<input type="checkbox"/>	Toileting / continence	<input type="checkbox"/>	-----
<input type="checkbox"/>	Preparing meals	<input type="checkbox"/>	-----
<input type="checkbox"/>	Walking	<input type="checkbox"/>	-----
<input type="checkbox"/>	Shopping	<input type="checkbox"/>	-----
<input type="checkbox"/>	Laundry	<input type="checkbox"/>	-----
<input type="checkbox"/>	Housework	<input type="checkbox"/>	-----
<input type="checkbox"/>	Going out	<input type="checkbox"/>	-----
<input type="checkbox"/>	Other please Specify:		-----

**6c. Can you tell us about changes in your life in the past year?**

**6d. What are the most important things you need help with?**

**6e. Family member or carer's views of problems, difficulty or concerns**

**6f. Do your family and / or carer agree with what you have said about your difficulties?**

**6g. Any other needs or difficulties experienced by you?**

**6h. SUMMARY OF ASSESSMENT NEEDS**

Service user name:

ID number:

### 7. Consent to share information

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**Information supplied will be held on an electronic database in accordance with the Data Protection Act 1998.**

The following are agencies and people who are generally, are able to help. Please indicate those, which you agree I can contact to share appropriate information.

- Social Care departments
- Friends/relatives – please name one or two
- Housing dept / Association
- Hospital Doctors and Nurses
- Community Nurses, Therapists (please specify)
- Other (please specify)
- General Practice
- Dept. of Works & pensions

**I agree you can share information with those people and agencies ticked above:**

**Signature of service user:** .....

**Name:** .....

**Date:** .....

Details of anyone you do NOT want contacted:

Details of anyone the informal carer does NOT want contacted:

### 8. Further Actions

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**Please indicate further action needed**

None		Provide information		Carer's assessment	
Specialist assessment		Referral		Continuing care assessment needed	
Overview assessment		Intervention		Nursing needs assessment	

**Details:**

### 9. Completed by

Confidential

**Assessors signature:**

**Date**

**Assessors name:**

**Designation**

**Assessment given to service user:**

**Date**