

Personal information

All the information in the following document is **CONFIDENTIAL**

In addition to gathering information to determine social care needs this narrative can identify service requirements, offered by other agencies. If the client has needs, which require support from another agency, please seek the client's permission to make onward referrals via the **FIRST CONTACT SCHEME**. The questions which generate **FIRST CONTACT** referrals are shown with a *. **IF services are to be accessed via FIRST CONTACT please print the narrative and pass it to the Out Of Hours Team, who will process the elements, which relate to First Contact.**

Title _____

Adult Care PIN _____
NHS No _____

Preferred name	<input type="text"/>
Gender	<input type="text"/>
Date of birth	<input type="text"/>
Address	<input type="text"/>
All Phone Numbers	<input type="text"/>
Email	<input type="text"/>
Current Address of the person (if living away from home)	<input type="text"/>
Marital status	<input type="text"/>
Nationality	<input type="text"/>
Ethnicity	<input type="text"/>
If other specify	<input type="text"/>
Religion	<input type="text"/>
Occupation (current/previous)	<input type="text"/>

Home details

Type of permanent accommodation	<input type="text"/>
Specify other if selected above	<input type="text"/>
Tenure of permanent accommodation	<input type="text"/>

Specify other if selected above

Is your housing situation satisfactory (homelessness, security of tenure, state of repair)

☐ Yes ☐ No

If no, would you like information on alternative housing*

☐ Yes (First Contact referral made) ☐ No
☐ Not applicable (answered yes above)

If no, would you like help, or advice, about arranging repairs to your home*

☐ Yes (First Contact referral made) ☐ No
☐ Not applicable (answered yes above)

Has your home been adapted to meet your needs

☐ N/A ☐ Yes ☐ Partially ☐ No

Do you have a working smoke alarm on each floor of your home*

☐ Not Required ☐ Yes ☐ No (First Contact referral made)

Would you like some fire safety advice*

☐ Yes (First Contact referral made) ☐ No

Would you like some advice on the security of your home*

☐ Yes (First Contact referral made) ☐ No

Are you currently using Telecare (equipment to keep you safe in your own home)

☐ Yes ☐ No

If no, would you like information on how to get a community alarm for if you get into difficulty*

☐ Yes (First Contact referral made) ☐ No

Are you able to keep your home warm (if caller would like advice on how to keep their home warm – select No to refer to agency)*

☐ Yes ☐ No (First Contact referral made)

Add details of above. If any of the above are 'no' consider what other universal services are available to assist e.g. handy van, trusted trader (no additional comments required if referred to First Contact)

Household details

Who lives with the person

- ☐ Person lives alone
- ☐ Spouse / partner **
- ☐ Dependent child / children **
- ☐ Person(s) over 18
- ☐ Person over 18 being cared for **
- ☐ Pets

Caring Role

- ☐ Person is being cared-for by another**
- ☐ Person provides care for another person **

If yes, would you like information on support available for Carers*

☐ Yes (First Contact referral made) ☐ No

****Create Personal Details for carer and cared-for and Link**

Visit information

Is your home a suitable and safe environment for visitors (access, hazards, adaptability)

☐ Yes ☐ No

Contact and visit details - important information for people to know when contacting or visiting you e.g. **access details** (when available / keyholder / preferred door / location e.g one way street) or **safety issues** (e.g. dog / known risks to others e.g. aggression)

☐ Key safe

Finances

Do you manage your own finances

☐ Yes ☐ No

Do you have difficulties managing your finances

(paying bills, living within your means)

☐ Yes ☐ No

Do you have difficulty applying for or receiving benefits

☐ Yes ☐ No

Receives attendance allowance

☐ Yes ☐ No

Receives disability living allowance

☐ Yes ☐ No

Would you like any advice on money you may be entitled to? (eg council tax reductions, attendance allowance, carers allowance, child and working tax credits)*

☐ Yes (First Contact referral made) ☐ Yes (income maximisation referral by CCA) ☐ No

Details of above and action taken e.g. what difficulties, particular benefit advice required for

Current support

Support or assistance from others (i.e. non social care)

- ☐ Family
- ☐ Health
- ☐ District nurse
- ☐ CPN

- ☐ Voluntary sector
- ☐ Private
- ☐ Other

Details of support and assistance provided (in the caller's view is the family's support: willing, able and sustainable)

Contacts

Next of Kin (pre-populated from linked persons)

Name	<input type="text"/>
Home phone number	<input type="text"/>

Main Carer (pre-populated from linked persons)

Name	<input type="text"/>
Home phone number	<input type="text"/>

Emergency Contact (pre-populated from linked persons)

Emergency contact if not the above

First name	<input type="text"/>
Last Name	<input type="text"/>
Home phone number	<input type="text"/>

GP (pre-populated from personal details screen)

GP Practice	<input type="text"/>
GP Address	<input type="text"/>
GP Telephone	<input type="text"/>

Other Involved Person(s) (additional family members if not linked already / other professionals e.g. hospital consultant) - 1

Name	<input type="text"/>
Role / relationship	<input type="text"/>
Organisation if applicable	<input type="text"/>
Address	<input type="text"/>
Telephone numbers	<input type="text"/>

if the client requires someone to respond on their behalf to phone calls, or queries, in relation to First Contact referrals, please add their name and number

Referral details

Person making contact

Referrer's name	<input type="text"/>
Referrer's address	<input type="text"/>
Referrer's phone number	<input type="text"/>

Referral source

Referral method

Person being referred (complete if not self referral)

☐ Is aware of the referral

☐ Will be informed of the referral by the referrer

☐ Has not been informed of the referral

☐ Is this referral to avoid an acute Hospital admission

Caller's own words

Your personal background (personal history, family relevant to the referral)

How would you like your situation to improve (include current concerns, difficulties and recent changes

•AND

Your personal and family history, strengths, culture, social network

Your family, carer(s) or advocate's view of your situation and what would improve it

Conditions (pre-populated from personal details screen)

Condition

Main disability, impairment or health condition (check only one field)

☐ None known

☐ Arthritis

☐ Autism / autistic spectrum

☐ Cancer

☐ Cardiac Condition

☐ Dementia (including Alzheimers)

☐ Depression / anxiety

☐ Diabetes

☐ Epilepsy

☐ Fracture

☐ Head injury

☐ Learning disability

☐ Neurological condition

☐ Physical impairment

☐ Respiratory condition

☐ Sensory impairment

☐ Serious infection (viral or bacterial)

☐ Severe mental illness

☐ Stroke

☐ Other mental health problems

☐ Other physical illness

Additional disabilities, impairments or health conditions (check as many fields as required)

☐ None known

☐ Arthritis

☐ Autism / autistic spectrum

☐ Cancer

☐ Cardiac Condition

☐ Dementia (including Alzheimers)

☐ Depression / anxiety

☐ Diabetes

☐ Epilepsy

☐ Fracture

☐ Head injury

☐ Learning disability

☐ Neurological condition

☐ Physical impairment

☐ Respiratory condition

☐ Sensory impairment

☐ Serious infection (viral or bacterial)

☐ Severe mental illness

☐ Stroke

☐ Other mental health problems

☐ Other physical illness

Type of sensory impairment

☐ No visual impairment ☐ Sight impaired ☐ Severely sight impaired ☐ No hearing impairment ☐ Hard of hearing ☐ Deaf

Details of your health and sensory needs (include relevant details of medical history, recent admissions or procedures, physical impairments, sensory impairments, whether permanent and/or substantial condition and which condition is regarded as the primary condition) **and aids used**

Preferred language

☐ Interpreter required

Do you have communication difficulties

Are you unsteady on your feet or have you fallen in the last 12 months

☐ Yes ☐ No

Would you like a referral to the falls clinic (if appropriate)*

☐ Yes (First Contact referral made) ☐ No

If yes, state cause and /or frequency of falls (if known)

CONSENT

Has the client given consent for the information to be shared as needed with statutory agencies*

☐ Yes
 ☐ Yes but with limitations - add warning note

☐ No - add warning note
 ☐ Unable to consent - no family/representative

☐ Unable to consent - consent given by family / representative

To access services via FIRST CONTACT the client, or their representative must give their consent

Details of any limitation

Date of contact

Your emotional well-being and mental health

Have you had contact with mental health services in the last year

☐ Yes ☐ No

Details of MHS contact

Can you provide us with additional details

Would you like information on social and recreational activities in your area*

☐ Yes (First Contact referral made) ☐ No

Would you be interested in becoming a volunteer*

☐ Yes (First Contact referral made) ☐ No

Would you like information on community transport*

☐ Yes (First Contact referral made) ☐ No

Would you like information on the FREE home library service*

☐ Yes (First Contact referral made) ☐ No

Would you like information on local Adult Education Courses*

☐ Yes (First Contact referral made) ☐ No

Would you like advice on living a healthier, more active lifestyle*

☐ Yes (First Contact referral made) ☐ No

Domestic Abuse

Please complete the following fields ONLY when the referral is regarding domestic abuse.

All 7 questions must be answered

1. Has the abuse got worse or more frequent over the past few months

☐ Yes ☐ No

2. Is the victim trying to separate from/ has recently separated from the alleged perpetrator

☐ Yes ☐ No

3. Has the victim been injured, or alleging to have been injured during the recent incident

☐ Yes ☐ No

4. Was the incident:

☐ Physical ☐ Verbal ☐ Sexual

5. Were any weapons used: knives, gun, glass, bottles

☐ Yes ☐ No

Specify

6. Were any verbal threats made to the victim/child

☐ Yes ☐ No

7. Is the person very frightened

☐ Yes ☐ No

If yes what are they
frightened of

If the answer to Q1 or Q2 is yes or if 5 yes answers in total make a safeguarding referral

Referral Outcome

Actions completed

- ☐ Information and advice provided
- ☐ Signposting (resources, organisations and services e.g. Trusted Trader / charities / voluntary groups)
- ☐ First Contact referral(s) made
- ☐ Simple equipment provided
- ☐ Carers assessment (Derbyshire Carers Association)

Actions completed before referral to area

- ☐ Caller has been advised this is an adult referral
- ☐ Caller has been advised service provision is subject to an assessment of need
- ☐ Caller has been advised that needs and individual circumstances are screened against FACS
- ☐ Caller has been advised a co-funding contribution may be required and a referral has been made
- ☐ Caller has been advised there is an intention to start the assessment process within 28 days depending on the priority of need
- ☐ Caller's preferred method of communication has been ascertained and recorded
- ☐ The person has been subject to previous signposting
- ☐ Domestic abuse - MARAC risk assessment to be completed by area

Name and Designation of the person completing form*

Date form completed