

**ENQUIRY FORM**



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| **Received by:**  | **Date received:** |
| **REFERRER** |
| **Referrer name:**  |  |
| **Organisation:**  | **Role:** |
| **Address:** |
| **Phone:**  | **Email:** |
| **Relationship to person:**  |
| **How did you near about us:** |
| **Has client given permission for contact? Yes/No**  | **Method:** |
| **If no, who should we contact?** |
| **Has the client given consent for Ageing Well to hold their details? Yes / No** |
| **Do they require an assessment? Yes / No** | **Does someone need to be there? Yes / No** |
| **Are there any known, immediate or potential risks to visiting this person? Yes/No****If yes, please detail** (eg: aggressive dog, uneven access, trip hazards etc): |
| **CLIENT DETAILS (if different from above)** |
| Title (Mr/Mrs/Ms/Miss/Dr/Rev/Other):  |
| Surname: |
| First Name/s: | Preferred Name:  |
| Address (line 1): |
| Address (line 2): |
| Town: | Postcode |
| Main Telephone Number: |
| Other Telephone Number: |
| Gender: Male / Female | Date of Birth |
| Email Address: |
| **EMERGENCY CONTACT DETAILS** |
| Name: | Relationship: |
| Main contact number: |
| Other phone number: |
| GP: Name of GP (if known):  |
| Surgery: Telephone Number: |
| **HOME AND PERSONAL CIRCUMSTANCES /**  |
| (e.g. lonely, fallen, bereaved, no family visiting on a regular basis, depressed/anxious, hoarding) |
| **REASONS FOR REFERAL / DESIRED OUTCOMES**: |
| (eg: regain confidence, build strength/balance, clean environment, reduce isolation, inclusion etc) |
| **HEALTH** |
| Alzheimer’s/Dementia |  | Depression/Anx |  | Memory loss |  | Respiratory |  |
| Arthritis |  | Drug/alcohol |  | ME/MS |  | Sensory – hearing |  |
| Cancer |  | Epilepsy |  | Mobility |  | Sensory – sight |  |
| Cardiac |  | Learning Dis |  | Neurological |  | Stroke |  |
| Diabetic |  | Mental Health |  | Parkinsons |  | Other |  |
| **Known allergies:** |
| **Current support** (eg: family, carer): |
| **Interests / personality / past:** (eg: hobbies, holidays, chatty/quiet) |
| **SERVICES**  |
| **Active and Connected**(Exercise and community connecting) |  | **Help at Home** (A charged for service providing cleaning, laundry, shopping etc.) |  |
| **Guidance/ Form Filling / F.I**(Support with simple paperwork tasks – sorting post, form filling, IT help) |  | **Other:** |  |
| **Sitting Service** (A charged for service) |  |  |  |
| **Preferred day of week:** | **Preferred time: AM / PM** |
| **ACTIVITIES** |
| Seated exercise |  | Balance / Tai Chi |  |
| Social inclusion |  | Singing for health |  |
| Walking |  | Memory  |  |
| Arts/crafts |  |  |  |
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| We refer all our members to the Fire Service to receive a Free Home Fire Safety Visit. Would the client like to be referred to D&SFS? | **Y** | **N** |

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| **Signed:** | **Date:** |

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| **Project Coordinator Action:** |
| **Date:** | **Action:** |
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| Added to Charity Log | Inits: | Date: |

AB/BP/JN/DS 07/05/2019