**CareLink – Registration Form**

1. **Applicants Contact Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Forename  |   | Surname |  |
| Title |  | Preferred Name |  |
| Gender |  | Date of Birth |  |
| 1st Language |  | Ethnicity |  |
| Address |  | Religion |  |
| Postcode |  |
| Main telephone number |  |
| 2nd telephone number |  |

1. **Type of residence:** please tick which applies

|  |  |  |  |
| --- | --- | --- | --- |
| Privately owned | Privately Rented  | Social Landlord | Housing Association |

1. **Next of Kin details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Phone Number |  |
| Address |  | Relationship to applicant |  |

1. **Medical matters:**

|  |  |  |  |
| --- | --- | --- | --- |
| Doctors surgery nameand address  |  | Telephone number |  |
| Current medical conditions |  |

1. **Details of other professionals involved**

|  |  |  |
| --- | --- | --- |
| Name | Service e.g. Adult Social Care or District Nurse | Nature of support they provide  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Social worker?** | **Name** | **If no, date client referred by Carelink** |

1. **If you are referring someone else for CareLink services or opportunities please complete this section if no go to section 7 below.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of referrer: |  | Job title: |  |
| Organisation Address: |  | Telephone number: |  |
| Email:  |  |
| Preferred method of contact? |  | Best times to contact? |  |
| Permission given by applicant for you to make this referral on their behalf ? | Yes |  | No |  |

1. **Getting in touch**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Should we make initial contact directly with the applicant? | Yes |  | Details: | e.g. Name, contact number, relationship to applicant |
| No |  |
| Does the applicant live alone? | Yes |  | Details: | e.g. this person is classed as a carer for their son who lives with them |
| No |  |
| Does the applicant receive regular practical support from anyone? | Yes |  | Details:  | e.g. carers in daily/weekly; family hands on with daily support |
| No |  |
| Does the applicant have any regular visitors? | Yes |  | Details: | e.g neighbour pops round for cuppa occasionally;  |
| No |  |
| Does the applicant have any pets or other animals? | Yes |  | Details: |  |
| No |  |
| Any parking or access issues? | Yes |  | Details: |  |
| No |  |

1. **Registration Criteria** please tick all that apply and give as much detail as possible to enable the best possible outcome

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** |  |
| 1.Is the applicant aged 65 or over? |  |  |  |
| 2. Do they need early intervention support to avoid a crisis? |  |  |  |
| 3. Do they want support to improve health by preventing social isolation? |  |  |  |
| 4. Do they present with the early identification of signs of declining or diminished capacity/capability? |  |  |  |
| 5. Do they present with the early identification of potential abuse? |  |  |  |
| 6. Do they present with signs of self-neglect? |  |  |  |

1. **What intervention do you think the applicant needs/wants?**

|  |
| --- |
|  |

1. **What would happen if this application was declined?**

|  |
| --- |
|  |

**Office use only:**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant UCR: |  | Date of Registration: |  |
| Registration taken by: |  | Staff Signature: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Initial registration accepted? | Yes |  | If no reasons declined |  |
| No |  |
| Initial phone assessment accepted? | Yes |  | If no reasons declined |  |
| No |  |
| Date of IPA& reasons for delay if late |  | Completed by: |  |
| Initial home assessment accepted? | Accepted |  | If no reasons declined |  |
| NFA |  |
| Date of IHA& reasons for delay if late |  | Completed by: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Project start date: |  | Project end date: |  |
|  |
| Project assigned to: | ASC |  | 6 week progress reviewDate due: Date done:Staff initials: | Comments: |
| BLF |  |
| CCG |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Service History** | Start date | End date | Project |
| Very first date introduced to CareLink Services |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| Project end date: |
|  |  |  |  |
|  |
| Project ended because: | Deceased |  | Staff initials: | Comments: |
| Needs too high |  |
| Needs reduced |  |