# Ribble Valley Homes
# Call Centre Information Form

Ribble Valley HOMES

**PLEASE USE BLOCK CAPITALS**

Equip Type: ..... Serial No: ..... Sch: ..... Idt: ..... Gold: ..... Silver: ..... Bronze: .....

Telecare Sensors - What Types? .....

Title: ..... Surname: ..... First Name(s): ..... D.O.B: .....

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Cohabiting ☐ Civil Partnership

House Name/Number: ..... Street: .....

Area: ..... Town: ..... Postcode: .....

Telephone: ..... Mobile: .....

Type of Housing: ☐ House ☐ Bungalow ☐ Flat ☐ Other

Living Arrangements: ☐ Lives alone ☐ Couple ☐ N.O.K. ☐ Other

Ethnic Origin: ..... Religion: ..... NI Number: .....

Housing Benefit Claimed? ☐ Yes ☐ No

Preferred Language: ..... Other - please state: .....

Do you need the information in: ☐ Large Print ☐ Braille ☐ Audio

Doctor: ..... Address: .....

.....

Town: ..... Telephone No: .....

**Medical Information** - How does your health affect you? .....

.....

.....

**Personal Details - Personal Contacts**

**Name:** ..... Address: .....

Relationship: ..... Tel No: ..... Work/Mobile: ..... Key: .....

Availability: .....

**Name:** ..... Address: .....

Relationship: ..... Tel No: ..... Work/Mobile: ..... Key: .....

Availability: .....

**Name:** ..... Address: .....

Relationship: ..... Tel No: ..... Work/Mobile: ..... Key: .....

Availability: .....

**Personal Support Plan**

| | Yes | No |
|---|---|---|
| Care Package | ☐ | ☐ |
| Personal Hygiene | ☐ | ☐ |
| District Nurse | ☐ | ☐ |
| C.P.N. | ☐ | ☐ |
| Chiropodist | ☐ | ☐ |
| Probation | ☐ | ☐ |
| Social Worker | ☐ | ☐ |
| Meals on Wheels | ☐ | ☐ |
| Day Care | ☐ | ☐ |
| Family Support | ☐ | ☐ |
| Regular Medication | ☐ | ☐ |

Care Information/Medical Support Contacts

Agency: .....

Visits, how often? .....

Hospital: ..... Private: .....

Name: ..... Tel No: .....

How often? M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su ☐ Supplier: .....

Location: ..... Day(s): ..... Tel No:.....

How often? .....

How many times daily? .....

**Do you have any of the following?** (please tick)

| | | | |
|---|---|---|---|
| Allergies | ☐ | Physical health problems | ☐ |
| Disturbed sleep patterns | ☐ | Problems self-medicating | ☐ |
| Communication problems | ☐ | Learning disability | ☐ |
| Emotional problems | ☐ | Impaired sight | ☐ |
| Problems with self care inc. mobility | ☐ | Hearing difficulties | ☐ |
| Drug/alcohol issues | ☐ | Literacy problems | ☐ |

Key Location .....

Scheme .....

Tag .....

Directions .....

If yes, please give details .....

**Property Risk Assessment**

Parking ☐ Roadside ☐ On driveway ☐ Directly opposite

Nearest parking location - please state: .....

| Lighting | Front of property | | Rear of Property | |
|---|---|---|---|---|
| Street Lighting | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| Security Lighting | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| Torch required | Yes ☐ | No ☐ | Yes ☐ | No ☐ |

Obstructions - Free from obstructions? Please state - eg overgrown shrubs etc: .....

.....

Pathways? Please state - eg uneven? Trip hazard? .....

| Access front door | | Access rear door | |
|---|---|---|---|
| Double glazed | ☐ | Double glazed | ☐ |
| UPVC | ☐ | UPVC | ☐ |
| Hardwood | ☐ | Hardwood | ☐ |
| Security glazed | ☐ | Security glazed | ☐ |
| Glazed | ☐ | Glazed | ☐ |

Fences & Gates - How would we gain access to rear of property? Please state - eg are gates locked? .....

.....

Location - comments: .....

Security - is the property alarmed? Yes ☐ No ☐ Mobile signal strength - please circle: 1 2 3 4 5

Location of alarm: .....

Property risk factor: ☐ High (10) ☐ Medium (5) ☐ Low (1)

Reason for risk: .....

Assessed by: ..... Date: .....

**Health & Safety in Your Home**

| | | |
|---|---|---|
| Do you use any aids or adaptations in your home? eg kettle tipper, bath aids etc | Yes ☐ | No ☐ |
| Are you able to move around easily in your home? | Yes ☐ | No ☐ |
| Do you use a walking aid or other adaptations? eg grab rail | Yes ☐ | No ☐ |
| Are there any trip hazards? eg trailing cables, rugs, badly fitted shoes | Yes ☐ | No ☐ |
| Are you able to get into the bath or shower? | Yes ☐ | No ☐ |
| Can you rise from a chair or knee height without using arms? | Yes ☐ | No ☐ |
| Can you manage steps and cope with internal stairs in your property? | Yes ☐ | No ☐ |
| Are the paths around your home well maintained? | Yes ☐ | No ☐ |
| Do you have any pets? Are they safe and friendly on entering your home? | Yes ☐ | No ☐ |
| Do you have a history of falling? If yes, what causes the fall? | Yes ☐ | No ☐ |

Is there anything else you consider involves you taking risks? .....

**Client Risk Assessment**

High ☐ Medium ☐ Low ☐ Warnings: Yes ☐ No ☐

Reason for risk: .....

What further support have you identified? .....

Is there anything else that you would like to add to your support plan? .....

Disability: .....

Routine visit: ..... Day: ..... Time: .....

Comments: .....

**PLEASE ATTACH AN ADDITIONAL SHEET FOR ANY FURTHER COMMENTS IF REQUIRED**