

HEALTH AND SOCIAL CARE

SINGLE ASSESSMENT MULTI-AGENCY CONTACT ASSESSMENT / REFERRAL FORM

Personal Details

Fields marked with an asterisk (*) are mandatory.

ISSIS Number NHS Number

Surname Forename (s)

Address Post Code

Tel. No D.O.B Ethnic Origin

Religion Gender: M / F Marital Status

Living Situation Tenure

Preferred Communication Signer/Interpreter Required (Yes / No)

Dentist Current/Previous Occupation

GP Address Tel. No

Next of Kin Relationship

Address Tel No

Name and Contact Details of Main Carer

Name and Contact Details of Other Carer

Contact Details for Keyholder

Has the assessment been carried out with a family member or carer rather than the person being assessed: Y / N
Reason (if yes)
Who has the assessment been undertaken with?

Name Relationship

Address

What are the presenting problems from the point of view of the person being assessed?

How long have these problems been experienced and how do they impact on the person's life?

Details of any recent changes in the person's life which could be related to the presenting problems.

Does the person have any solutions in mind?

Name of service user / patient

Views of family members/carers about the current situation.

Medical history, including recent hospital admissions and GP visits

Existing services – from any agency (including level and frequency)

Existing support from family and unpaid carers

Assessors comments

Risk to worker?

Carer Eligible for Assessment: Y / N
Name Relationship
Address Tel. No.
Carer Assessment Offered: Y / N Carer Assessment Accepted: Y / N

Has the Assessor Explained Information Sharing to the Person Being Assessed: Y / N
Has the Person Agreed to this: Y / N
If in Hospital:
Date of admission:
Date of Discharge:

Date completed* **Signed***.....
Print name and contact details of referrer:.....
.....
Forwarded to which agencies:.....