PERSONAL INFORMATION			
Name			
Address			
Postcode		D.O.B	
CONTACT DETAILS			
Home		Mobile	
Email			
NEXT OF KIN 1 – We require a minimum of one emergency contact			
Name			
Home		Mobile	
Email			
Power of Attorney	YES ☐	NO ☐	
NEXT OF KIN 2 (OPTIONAL)			
Name		Relationship	
Home		Mobile	
Email			
Power of Attorney	YES ☐	NO ☐	
ADVOCATE			
Will you require an advocate*?	YES ☐	NO ☐	
FUNDING AND INVOICING			
Who will be managing your payments? Please circle			
You	Advocate / Family	Local Authority	
How would you/they like your invoices sent? *Please circle* EMAIL/Post			
MEDICAL HISTORY			
GP name			
Address			
		Postcode	
Contact			

If you are currently taking medication can you please provide us with a list of your current medication using this form. *If you need additional space please provide this on another sheet of paper.*			
Medication 1		**Medication 2**	
Name		**Name**	
Dosage		**Dosage**	
Frequency		**Frequency**	
Medication 3		**Medication 4**	
Name		**Name**	
Dosage		**Dosage**	
Frequency		**Frequency**	
Medication 5		**Medication 6**	
Name		**Name**	
Dosage		**Dosage**	
Frequency		**Frequency**	

CURRENT HEALTH STATE	
How would you describe your current health state for the following?	
Sight	
Hearing	
Continence	
Will you need any special requirements with what you need support with? If yes please complete the box below	

YOUR SERVICES – HOW CAN WE HELP?	
I would like support with.... *Please circle*	
PERSONAL CARE	**MEAL PREPERATION**
HOUSE WORK	**MEDICATION**
COMPANIONSHIP	**SHOPPING**
OVERNIGHT ASSISTANCE	**OTHER**
Please supply a brief description (if other)	

If you know what days at times you would like visits please complete the table below* by ticking the box . Please enter an approximate time you would like your carer and the duration. If you do not know as of yet, this can be discussed at your consultation. *Example if you would like a lunch visit on a Monday, at half past twelve for 1 hour and 30 mins you would fill it in like this:*

☑ Please Tick

Time: _ 12.30
Duration:
_1_ hr _30_mins

DAYS	VISIT 1 MORNING	VISIT 2 LUNCH	VISIT 3 TEA	VSIT 4 EVENING
MON	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**

TUES	**Time: _____** **Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **___ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**
WED	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**
THURS	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**
FRI	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**
SAT	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**
SUN	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**	**Time: _____** **Duration:** **____ hr _____mins**

Where did you hear about Independent Homecare Team?			
SIGNATURE			
Name			
Signature			
Date			
OFFICE USE ONLY			
Date Received		**Office Ref**	
PP		**Consultation**	

*Please note that the information provided above is for information purposes only prior to your consultation. This document does not form a contract with Independent Homecare Team. This information is confidential and will not be shared with any third parties. We will only use this information in order to complete your care plan. If you do not choose care with IHCT we will destroy this information within 3 months following your decision. * advocate. Advocates rights are authorised by the client, if you do require care, Independent Homecare Team to be your care provider and wish to have an advocate, your chosen advocate will need to complete an advocate form in order to make care decisions on your behalf. *Times and days, at Independent Homecare Team we try our best to provide times which suit you, if for any instance the times you have requested are not available we will offer you a slot as close as possible until we can provide you with your requested time.