# SCC%20Logo%20Strapless%20SmallClient Details – Disability Service

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: |  | | | | | First names: | | |  | | |
| Current Address |  | | | | | Home Address (If different from current address.) | | |  | | |
| Date of Birth |  | | | | | Medical Card No. | | |  | | |
| Ethnicity: |  | | | | | Gender: | | |  | | |
| Nationality: |  | | | | | Language: | | |  | | |
| Immigration status: If applicable |  | | | | | PPS. number: | | |  | | |
| Care/legal status (if applicable): | | | | | |  | | | | | |
| Disability/diagnosis: | |  | | | | | | | | | |
| Family contact  (if applicable) | | **Name:**  **Tel:**  **Relationship to client:** | | | | | | | | | |
| Should family be contacted regarding support? | | | | | | | | | | | Yes  No |
| **Referring authority details** | | | | | | | | | | | |
| Referring/responsible authority: | | | |  | | | | | | | |
| Care Manager: | | | |  | | | | | | | |
| Address: | | | |  | | | | | | | |
| Telephone number: | | | |  | | | | | | | |
| Social Worker: | | | |  | | | | | | | |
| Address: | | | |  | | | | | | | |
| Telephone number: | | | |  | | | | | | | |
| Out of hours service contact: | | | |  | | | | | | | |
| **Request for Support from B.H.C.** | | | | | | | | | | | |
| Level of urgency re. referral | | | | | | | | | | High  Low | |
| Is the client aware a referral has been made? | | | | | | | | | | Yes  No | |
| Is the family aware a referral has been made? | | | | | | | | | | Yes  No | |
| Staffing support required: 1:1 2:1 Other | | | | | | | | | | *If others, please describe* | |
| **Placement support** | | | | | | | | | | | |
| Type of service requested: | | |  | | | | | | | | |
| Proposed period of engagement. | | | Start date: | |  | | | End date: | |  | |
| **Proposed days and Time (Please tick as applicable and indicate Total Hours required per Staff)** | | | | | | | | | | | |
| **Monday**  Morning  Afternoon  Evening  **Tuesday**  Morning  Afternoon  Evening  **Wednesday**  Morning  Afternoon  Evening  **Thursday**  Morning  Afternoon  Evening  **Friday**  Morning  Afternoon  Evening  **Saturday**  Morning  Afternoon Evening  **Sunday**  Morning  Afternoon  Evening  **TOTAL Hours in a Week per Staff =** | | | | | | | | | | | |
| **Client specific needs:** (Please include impact of disability, current presenting issues, areas of concern, priority issues to be addressed, strengths, weaknesses. Please indicate assessed level of ability re. Self-care) | | | | | | | | | | | |
| **Client risks:** (Please include risk to self and others)   |  |  |  |  | | --- | --- | --- | --- | | **Risk** | **Low** | **Medium** | **High** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | | | | | | | | | | |
| **Service requested** | | | | | | | | | | | |
| **Details of service requested:** (Please indicate proposed level of support required; **include** requirements for personal care, food, medication.) | | | | | | | | | | | |
| **Staff required:** Male: Female: Either: | | | | | | | | | | | |
| **Is parking space available to support staff?** Yes  No | | | | | | | | | | | |
| **Financial arrangements/support: i.e does the client require petty cash or a car as part of their support package?** | | | | | | | | | | | |
| **Any other information:**  (**include:** significant relationships, emergency contacts and who has parental responsibility if client is under 18) | | | | | | | | | | | |
| **Placement plan, risk assessment & information sharing** | | | | | | | | | | | |
| Please attach a copy of any relevant paperwork in respect of this client, such as risk assessments, medical reports etc. | | | | | | | | | | | |
| Review Dates/Methodology (Proposed) | | | | | | |  | | | | |

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| --- | --- | --- | --- |
| Form completed by: |  | | |
| Signature: |  | Date: |  |
| Manager: |  | | |
| Signature: |  | Date: |  |

**Please return completed form to:** [naomi.s@barroghealthcare.ie](mailto:naomi.s@barroghealthcare.ie)