



SHORT BREAKS SERVICES

APPLICATION FORM for SITTING & BEFRIENDING SERVICES (Adults)

Applications can only be completed for people residing in Broxtowe, Gedling and West Bridgford as part of the block contract service agreement. Applications from other parts of Rushcliffe, Hucknall and Nottingham City accepted for Service Users with individualised budget /agreed funding e.g. from panel, direct payments.

Please return the application form to:

Tania Comery, Short Breaks Service Manager,
Harpenden House, 203 Edwards Lane,
Sherwood, Nottingham. NG5 3JA
or e-mail to shortbreaks@positivefutures.org.
Tel: 0115 9204433

The information given will be confidential, however it will be shared with potential workers so a match can be made.

To be completed in consultation with carers.

PLEASE COMPLETE THE FORM USING BLOCK CAPITALS

DETAILS OF SERVICE REQUIRED

SITTING SERVICE

BEFRIENDING SERVICE

TRANSITION SUPPORT SERVICE

LIFESTYLE SUPPORT SERVICE

DETAILS OF THE ADULT WITH A LEARNING DISABILITY

Surname

First name

Date of birth

Gender

PARENTS /CARERS DETAILS

Surname

MR/MRS/MS/MISS

First Names

Relationship to Service User

Address

Telephone number where we can contact you

Home

Work

Mobile

E-mail

Please give names of any other carers in the household.

Has a Carers' Assessment been completed?

YES

NO

ADULT'S DAYTIME ACTIVITY

Name, address and telephone number of workplace, college, day centre etc.

MEDICAL INFORMATION

Name, Address and Telephone Number of Doctor (GP)

Diagnosis / level of disability (i.e. Autism, Downs Syndrome, etc)

Please give details of any physical disability (including hearing and visual impairment).

Long-term health conditions (e.g. epilepsy, asthma, and diabetes). Please give details,

Treatments, procedures and medication. Please specify drug and dosage.

PLEASE NOTE WORKERS ARE NOT ALLOWED TO ADMINISTER ANY MEDICATION.

The service is therefore unable to accept anybody liable to require emergency medication. The information below is required for other medical emergency situations.

NAME OF MEDICATION	DOSAGE	TIME GIVEN

PERSONAL CARE NEEDS

EATING AND DRINKING

Can eating and drinking be done independently? YES NO

If no, how much support or supervision is needed?

Likes, dislikes, and any dietary needs:

SLEEPING

Usual bed times:

Week-day

Week-end

Is there a special bedtime routine? Please note that workers are not normally trained in manual handling procedures. We are therefore unable to accept anyone onto the service who would require lifting.

USE OF TOILET

Can he /she go to the toilet independently?

YES

NO

What help, if any, is needed?

Continence (Consider management regimes, incontinence, menstruation)

WASHING/BATHING

Can washing & bathing be done independently?

YES

NO

What kind of supervision is necessary?

DRESSING/UNDRESSING

Can dressing/undressing be done independently ?

YES NO

What kind of supervision is needed?

CULTURAL AND RELIGIOUS NEEDS

Ethnic Origin

Religion

Sexuality

Please give details of any needs relating to the above, that the worker needs to take into account.

COMMUNICATION

Please give details about communication needs.

Is Makaton or any other special communication system used? Consider hearing, understanding and expression. Please specify mother tongue if not English.

SOCIAL BEHAVIOUR

Consider challenging behaviour and harm to self or others. Identify any known trigger factors.

HOBBIES AND INTERESTS

Please give details

Possible activities to be engaged in with the Support Worker, and preferred times/days of the week for sessions to take place:

OTHER RELEVANT PROFESSIONALS e.g. Social worker/Community nurse/Teacher

Name

Telephone number

ADDITIONAL INFORMATION

Please give details of any other respite services that are used.

Please give names of additional people (e.g. siblings) who also need to be cared for if sitting service required.

Name

DOB if under 18

Details of a helpful relative or neighbour that the worker may contact if necessary

Name

Telephone number

Pets in household (e.g. cats and dogs) Please give details

Would it be necessary for the worker to keep the outer doors locked?

YES NO

Is there any other information that you feel is relevant (e.g. any known risks)? Please give details.

Please give details of funding arrangements, e.g panel, Direct Payments, expenses arrangements. If paying by panel, please state desired number of hours of service per month.

DETAILS OF THE PERSON MAKING THIS REFERRAL

Name

Position

Where based

Contact Telephone Number

E-mail Address

Date