1 Enquiry Form

PROSPECTIVE SERVICE USER					
Surname:		**First Name(s):**		**Title:**	
Likes to be known as:		**Marital Status:**		**DOB:**	**Age:**

Address:

Tel No:

PRELIMINARY REQUIREMENTS FOR CARE						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM:	AM:	AM:	AM:	AM:	AM:	AM:
PM:	PM:	PM:	PM:	PM:	PM:	PM:

Period of Day	Duties	No. of Carers required
MORNING :		
AFTERNOON:		
TEA TIME:		
EVENING:		
Domestic Cleaning:		

PERSON MAKING ENQUIRY OR NEXT OF KIN DETAILS

Name:

Address:

Tel No:

Relationship to Prospective Service User:

Name:

Address:

Tel No:

Relationship to Prospective Service User:

MEDICAL QUESTIONS
Doctor Name: **Address:** **Contact Details:**
Other Acting agencies/ services: **Address:** **Contact Details:** **Details:**
Other Acting agencies/ services: **Address:** **Contact Details:** **Details:**
Other Acting agencies/ services: **Address:** **Contact Details:** **Details:**

IMPORTANT QUESTIONS		
QUESTIONS		**ANSWERS**
What parts of your body do find is difficult to move and bend?		
What parts of your body can you feel?		
What parts of your body can you not feel?		
What helps to relieve your pain?		
In relation to the pain you feel, if 10 is your best on a good day and 0 is your worst on a bad day, what do you feel is your pain today.		

Are there any tasks you consider difficult to complete on your own. For example filling up a separate flask for the day because the kettle may be too heavy to hold?		
Are there any items you would like us to move in order to make it easier for you to reach and / or relieve your pain?		
Are there any aids you can use to help with daily tasks.		
Assessment requests:		
Additional Information:		

CONSULTATION
Date of first meeting:
Date services due to commence:
Actions to follow:

ENQUIRY TAKEN BY
Print Name*:* **Date*:***