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

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| 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 |
| **Placement support** |
| Type of service requested: |  |
| Proposed period of engagement. | Start date: |  | End date: |  |
| **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)

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| **Risk** | **Low** | **Medium** | **High** |
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| **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: |
| **Number of staff per shift (1:1, 2:1 etc.):** |
| **Financial arrangements/support:**  |
| **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 form to:** naomi.selim@barroghealthcare.ie or james.brady@barroghealthcare.ie