MANCHESTER
CITY COUNCIL

NHS

Contact Assessment Form - Part 1

Manchester Contact Services (Social Care) Tel: 0161 255 8250 Fax: 0161 255 8266
Please complete all fields as fully as possible

Section 1: Personal Details

Title: ..... Surname: ..... Forename: .....

Known as: ..... D.o.B.: ..... Male ☐ Female ☐

Permanent address: .....

..... Postcode: ..... NHS No: .....

Telephone no: ..... If ex-directory can number be shared? Yes ☐ No ☐

Religion: ..... Ethnicity: .....

Current/previous occupation: .....

Name/address/tel. no. of main carer (for emergencies): .....

.....

.....

Does the person being referred have any caring responsibilities? Yes ☐ No ☐

If in hospital please complete - Ward: ..... Date of admission: .....

Section 2: Communication

First language: ..... Is an interpreter required? Yes ☐ No ☐

*Is an advocate required? Yes ☐ No ☐ Are there any other communication difficulties? Yes ☐ No ☐

If yes please specify: .....

Safety/Access Issues: *Are there any safety issues? Yes ☐ No ☐

If yes please give details .....

Current address (if different from above): .....

.....

Section 3: Household Members and Significant Others

Name	Sex	DoB	Relationship	Address & tel No (if different)	Tick if also referred

Section 4: Key Agencies Involved

	Name & Address	Tel/Fax/Email
GP		
Dentist		
Pharmacist		
Other		
Other		

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Contact Assessment Form - Part 2

Name: .....

Section 5: Type of Accommodation

Local authority ☐ Owner occupier ☐ Private rented ☐ Housing association ☐ Other ☐

If other, please give details: .....

Does the person being referred live alone? Yes ☐ No ☐

Section 6: Permanent or Longstanding Health Conditions or Disabilities

Section 7: Reason for Referral

What is the presenting problem from the point of view of the person being referred? Please include the significance and length of time the problem has been experienced, including any significant life events.

What is the presenting problem from the point of view of the referrer?

Are there any other problems the person is experiencing?

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Contact Assessment Form - Part 3

Name: .....

What are the preferred solutions/expectations?

What are the views of the carers/family members?

Section 8: Services Currently in Place

Social care .....

Health .....

Voluntary/private sector .....

Section 9: Referrals Made to Other Agencies

Professional/Agency	Address/Contact details	Date referral made

Section 10: Details of the Person Making Referral

Name: .....

Address: .....

Postcode: .... Telephone no: .....

Relationship to person being referred: .....

Locality: ..... Date: .....

Is the person being referred aware of this referral? Yes ☐ No ☐

Is their family aware of the referral? Yes ☐ No ☐

Has the person given their consent to information about them being shared with other professionals? Yes ☐ No ☐