West Dunbartonshire Community Health Partnership · NHS Greater Glasgow and Clyde · West Dunbartonshire Council

Form Details

Form Start Date: 29/03/2018	Worker Name: Susan Mcgrory

Person Details

Name: Tier One And Two Test	**CareFirst ID:** P98553
DoB / EDD: 06/06/1949	**Gender:** Unknown
Address: 15 Garshake Road, Dumbarton, G82 3LH	**Tel No:** 01389776840

Information about Carer

Source of Referral for Adult Carer Support Plan assessment to be carried out:

Adult Carer Support Plan Type:

Has the Adult Carer Support Plan been carried out as part of a joint assessment with the cared-for person?

Is the carer eligible for support?

CHI Number:

Number

PREFERRED/ALIAS NAME:

Title	First Names	Surname

MARITAL STATUS:

Category:

Notes:

ETHNICITY:

Category:

Notes:

EVENING CONTACT NUMBER (if different from above)

Name: Tier One And Two Test **CareFirst ID:** P98553

MOBILE NUMBER:

IS THE CARERS ADDRESS, AND CONTACT NUMBER/S CORRECT AND MATCH WHAT IS CURRENTLY CORRECT AT THE TOP OF THE SCREEN?

If no please ensure you update via the person details screen.

DO YOU HAVE ANY ISSUES WITH COMMUNICATION?

PROVIDE DETAILS:

WHAT YOUR RELATIONSHIP TO THE CARED-FOR PERSON?

HOW LONG HAVE YOU BEEN CARING FOR THE PERSON?

THE NUMBER HOURS OF CARE YOU PROVIDE PER WEEK TO THE CARED FOR PERSON:

FROM THE LIST BELOW PLEASE MARK YES BESIDE ALL THAT APPLY, USE THE COMMENTS FIELD TO RECORD ANYTING NOT LISTED.

	Type of Care Provided
Help with Medication	
Help with Personal Care	
Help with shopping, cleaning, domestic tasks	
Help with transport	

Name: Tier One And Two Test **CareFirst ID:** P98553

	Type of Care Provided
Supervision / Emotional Support	
Financial Support	
Other	
Not Known	
Comments	

YOUR GP DETAILS:

Relationship:
Name:
Address:
Email:
Phone:
Notes:

DO YOU HAVE ANY OF THE FOLLOWING RESPONSIBILITIES FOR THE PERSON YOU CARE FOR?

	o
APPOINTEE	
GUARDIAN welfare	
GUARDIAN financial	
GUARDIAN both	
NAMED PERSON	
POWER OF ATTORNEY welfare	
POWER OF ATTORNEY Financial	
NONE OF THE ABOVE	

Name: Tier One And Two Test **CareFirst ID:** P98553

	o
OTHER specify below	
o	

DO YOU REQUIRE INFORMATION OR ADVICE REGARDING THE ABOVE?

Information about Cared For Person

HOME ADDRESS AND CONTACT DETAILS OF THE PERSON YOU CARE FOR
Relationship: **Name:** **Address:** **Email:** **Phone:** **Notes:**
DO YOU LIVE WITH THE PERSON YOU CARE FOR?
PROVIDE DETAILS OF ANY OTHER PEOPLE YOU CARE FOR AND ANY ADDITIONAL CARERS

Carer Assessment Information

HAS THE PERSON YOU CARE FOR HAD AN ASSESSMENT?
PROVIDE DETAILS
IF YES, ARE YOU SATISFID WITH YOUR LEVEL OF INVOLVEMENT IN THE ASSESSMENT CARE AND SUPPORT OF THE PERSON YOU CARE FOR?
PROVIDE DETAILS

Name: Tier One And Two Test **CareFirst ID:** P98553

SUMMARY OF THE SITUATION OF THE PERSON/S YOU CARE FOR (including relevant illnesses/disabilities)
WHAT IS YOUR BACKGROUND IN BECOMING A CARER?
DESCRIBE WHAT YOU DO FOR THE PERSON YOU CARE FOR, HOW OFTEN YOU NEED TO DO THIS AND THE SERVICES AND SUPPORT YOU CURRENTLY RECEIVE

Life of your own

DOES YOUR CARING ROLE HAVE AN IMPACT ON YOUR HEALTH?
IF YES, PROVIDE DETAILS:
DOES YOUR CARING ROLE HAVE AN IMPACT ON YOUR EMOTIONAL WELL BEING?
IF YES, PROVIDE DETAILS:
DO YOU FEEL VALUED IN YOUR CARING ROLE?
PROVIDE DETAILS:
PLEASE DESCRIBE YOUR SOCIAL LIFE, LEISURE ACTIVITIES, RELIGIOUS & CULTURAL ACTIVITIES:

Name: Tier One And Two Test **CareFirst ID:** P98553

DOES YOUR CARING ROLE HAVE AN IMPACT/AFFECT YOUR ABILITY TO BALANCE YOUR SOCIAL LIFE, AND ACTIVITIES?

IF YES, PROVIDE DETAILS:

DOES YOUR CARING ROLE HAVE AN IMPACT ON YOUR LIVING ENVIRONMENT?

KEY RELATIONSHIPS - DESCRIBE SITUATION:

DOES BEING A CARER AFFECT YOUR RELATIONSHIPS WITH OTHERS, INCLUDING THE PERSON YOU CARE FOR?

IF YES, PROVIDE DETAILS:

DOES YOUR CARING ROLE HAVE AN IMPACT ON EMPLOYMENT, EDUCATION, TRAINING AND LIFELONG LEARNING?

IF YES, PROVIDE DETAILS:

IF NOT IN WORK, WRE YOU INTERESTED IN FINDING OUT MORE, INCLUDING TRAINING OPPORTUNITIES?

PROVIDE DETAILS:

Name: Tier One And Two Test **CareFirst ID:** P98553

DOES YOUR CARING ROLE HAVE AN IMPACT ON FINANCES I.E THE MANAGEMENT AND LEVEL OF FINANCES?

IF YES, PROVIDE DETAILS:

HAVE YOU BEEN OFFERED AN INCOME MAXIMISATION ASSESSMENT?

PROVIDE DETAILS:

WOULD YOU BENEFIT FROM A SHORT BREAK IN ORDER TO CONTINUE YOUR CARING ROLE?

Emergency/Crisis Planning

IF YOU WERE UNAVAILABLE, WOULD ADDITIONAL SUPPORT BE REQUIRED FOR PERSON YOU CARE FOR?

IF YES, YOU MUST RECORD THE EMERGENCY CONTACT PERSON:

Relationship:
Name:
Address:
Email:
Phone:
Notes:

ARE THERE ANY PLANS IN PLACE FOR EMERGENCY OR CRISIS PLANNING?

IF YES, PROVIDE DETAILS

IF NO, WHAT WOULD NEED TO BE DONE IF AN EMERGENCY AROSE?

Name: Tier One And Two Test **CareFirst ID:** P98553

The Future - Future Care Planning

DOES CARING HAVE AN IMPACT ON FUTURE PLANS:?

IF YES, PROVIDE DETAILS:

WHAT HOPES AND PLANS DO YOU HAVE FOR THE FUTURE?

ARE YOU WILLING TO CONTINUE IN YOUR CARING ROLE?

PROVIDE DETAILS:

DO YOU FEEL ABLE TO CONTINUE YOUR CARING ROLE?

PROVIDE DETAILS:

DO YOU HAVE ANY FUTURE ARRANGEMENTS IN PLACE TO CARE FOR THE CARED FOR PERSON?

IF YES DETAIL WHAT THESE ARE:

DO YOU WANT/NEED SUPPORT TO PLAN FOR THE FUTURE CARE OF THE CARED FOR PERSON?

Name: Tier One And Two Test **CareFirst ID:** P98553

IF YES WHAT DO YOU NEED?

Summary of Care and Identified Needs

	What support needs of the carer have been identified
Identified Need - Short Breaks or Respite	
Identified Need - Advice and Information	
Identified Need - Practical Support	
Identified Need - Counselling or Emotional Support	
Identified Need - Training and Learning	
Identified Need - Assist Benefits	
Identified Need - POA	
Identified Need - Other	
Identified Need - Not Known	
Identified Need - No Help	

IF THERE ARE OTHER SUPPORT NEEDS NOT IDENTIFIED ABOVE BE STATE BELOW:

SUMMARY AND DESIRED OUTCOMES OF THIS ASSESSMENT.

WHAT MIGHT HELP YOUR QUALITY OF LIFE AS A RESULT OF THIS ASSESSMENT?

Name: Tier One And Two Test **CareFirst ID:** P98553

HAVE YOU BEEN INFORMED WHO WILL COORDINATE SUPPORT AND HOW TO CONTACT THEM?

PROVIDE DETAILS

Date, Assessor Details and Declaration

ASSESSMENT START DATE	
ASSESSMENT END DATE	
CARE SUPPORT PLAN START DATE	

REVIEW DATE:

ANTICIPATED/PLANNED REVIEW DATE FOR CARER SUPPORT PLAN

NO LATER THAT SIX MONTHS

Activity Type:
Assigned To:
Status:
Status Date:
Requested Date:
Required by Date:
Priority:
Details:

ASSESSOR DETAILS

	o
ASSESSOR NAME	.
DESIGNATION	
AGENCY or ORGANISATION	

Name: Tier One And Two Test **CareFirst ID:** P98553

	o
ADDRESS	
CONTACT TEL NO	

I HAVE BEEN INVOLVED IN THIS ASSESSMENT AND PUTTING THIS SUPPORT PLAN TOGETHER
I FEEL THIS IS AN ACCURATE RELECTION OF MY SUPPORT NEEDS
I GIVE PERMISSION FOR MY INFORMATION TO BE SHARED WITH RELEVANT SERVICE PROVIDERS AND OR PEOPLE WHO WILL SUPPORT ME
I HAVE BEEN GIVEN A COPY OF THE SHARED ASSESSMENT SHARING INFORMATION AND GIVING CONSENT LEAFLET
SIGNATURE OF CARER

DATE	
SIGNATURE OF SUPPORT WORKER	
DATE	

Carers Support Plan

	Support Service provided or intends to provide
Support - Short Breaks or Respite	
Support - Advice and Information	
Support - Practical	

Name: Tier One And Two Test	**CareFirst ID:** P98553

	Support Service provided or intends to provide
Support - Counselling or Emotional	
Support - Training and Learning	
Support - Assist Benefits	
Support - POA	
Support - Other	
Support - Not Known	
Support - None	

WITH THE AIM OF SUPPORTING YOU IN YOUR CARING ROLE IN AN APPROPRIATE AND ACCEPTABLE WAY, YOU ARE ASKED TO CONSIDER THE NEEDS THAT YOU IDENTIFIED AND EXPLORE ALL OPTIONS/OPPORTUNITIES AVAILABLE TO YOU

	Need 1	**Need 2**	**Need 3**	**Need 4**
Summary of Support Needs	.			
Intended Outcomes				
Actions to meet Support Needs				
When will this be done				
Date actions completed				
Outcomes Achieved, If No, give reason/s in the box below				
o				

	Need 5	**Need 6**	**Need 7**	**Need 8**
Summary of Support Needs	.			

Name: Tier One And Two Test **CareFirst ID:** P98553

	Need 5	Need 6	Need 7	Need 8
Intended Outcomes				
Actions to meet Support Needs				
When will this be done				
Date actions completed				
Outcomes Achieved, If No, give reason/s in the box below				
o				

DETAIL ANY IDENTIFIED NEEDS THAT CANNOT BE MET AT THE MOMENT AND POSSIBLE CONSEQUENCES

Privacy Impact Statement	
West Dunbartonshire Health Social Care Partnership bring together both NHS Greater Glasgow & Clyde's and West Dunbartonshire Council's responsibilities for community-based health and social care services within a single & integrated structure	
Information will be held in both electronic and paper format and only be accessed by authorised personnel to provide you with the appropriate service within the Health Social Care Partnership.	
It may be necessary to share information with external agencies and if this is the case then we will ask you for consent if no statutory requirement exists.	
In order to comply with the Data Protection Act 1998 we will always ensure that any personal data we process will be handled fairly, lawfully and with justification.	
If you have any queries please discuss this with the member of staff who is supporting you.	

Name: Tier One And Two Test	**CareFirst ID:** P98553

Completion

Completed By: **Worker:** **Tel:** **Address:**	**Date:**