

**Resident Information sssv1.0Sheet**

**NO CURSIVE WRITING –**

**ONE CLIENT PER SHEET**

**HIGHLIGHTED FIELDS ARE MANDATORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Device:** |  | **For Housing Purposes Only** | |
| **Device Number:** |  | **Serial Number:** |  |
| **PLEASE ONLY SUPPLY THE DETAILS SPECIFIED ON THIS FORM** | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | MR  MS  MRS  MISS  DR  PROF  OTHER | | | | | | | | | | | | | | | | | | | | | Please specify: | | | | | | | | |
| **First Name:** | |  | | | | | | **Middle Name:** | | | | | |  | | | | | | | | **Surname:** | | | | |  | | | |
| **Address:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Town:** | |  | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | |
| **Postcode:** | |  | | | | | | **Type of Residence:** | | | | | | | | | House  Bungalow  Flat  Other | | | | | | | | | | | | | |
| **Date of Birth:** | | | |  | | | | **Language:** | | | |  | | | | | | | | | **Email:** | | |  | | | | | | |
| **Home Phone: (incl Area Code)** | | | | | | |  | | | | | | | | | | | | | | | **Mobile:** | | |  | | | | | |
| Key safe Code:  **(MARK ‘N/A’ IF NOT USED)** | | | | | | |  | | | | | | | | | Location: | | | | | | | | |  | | | | | |
| **Medical Conditions (e.g. asthma, heart conditions, diabetes (tablet or diet controlled) or any known allergies)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **None** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication (PLEASE TICK TO SELECT - LEAVE BLANK IF NOT USED):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Medication | | | | | | Insulin | | | | | | | | | Inhalers | | | | | | | | | | | Oxygen | | | | |
| Blood thinners  (Warfarin, Aspirin etc.) | | | | | | Aspirin | | | | | | | | | GTN Spray | | | | | | | | | | |  | | | | |
| **Do not resuscitate (DNR):**  **order in place** | | | | | |  | | |  | | | | | | | |  | | | | | | | | | | | | | |
| Location of Medicine: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **NHS Number:** | | |  | | | | | | | | **Pets:** | |  | | | | | | | | | | | | | | | | | |
| **Doctors Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Doctors Surgery Name:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **GP’s Name:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Town:** | | | | | |  | | | | | | | | | | | | | **Postcode:** | | | | | | |  | | | | |
| **Daytime Phone No:** | | | | | |  | | | | | | | | | | | | | **OOH Phone No:** | | | | | | |  | | | | |
| **Care Details (Social Worker, Care Worker, District Nurse, Meals on Wheels, Day Care Centre)**  **Name, Telephone number, address and days of attending:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency Contact 1** | | | | | | | | | | | | | | | **Emergency Contact 2** | | | | | | | | | | | | | | | |
| Name: | | | | |  | | | | | | | | | | Name: | | | | | | | |  | | | | | | | |
| Address: | | | | |  | | | | | | | | | | Address: | | | | | | | |  | | | | | | | |
| Town: | | | | |  | | | | | | | | | | Town: | | | | | | | |  | | | | | | | |
| Postcode: | | | | |  | | | | | | | | | | Postcode: | | | | | | | |  | | | | | | | |
| Relationship: | | | | |  | | | | | | | | | | Relationship: | | | | | | | |  | | | | | | | |
| Key Holder: | | | | | Y / N | | N.O.K: | | | Y / N | | | | | Key Holder: | | | | | | | | Y / N | | | | | N.O.K: | | Y / N |
| Email: | | | | |  | | | | | | | | | | Email: | | | | | | | |  | | | | | | | |
| Home No: | | | | |  | | | | | | | | | | Home No: | | | | | | | |  | | | | | | | |
| Mobile No: | | | | |  | | | | | | | | | | Mobile No: | | | | | | | |  | | | | | | | |
| Alternative No: | | | | |  | | | | | | | | | | Alternative No: | | | | | | | |  | | | | | | | |
| Completed by: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Date: |  |
| **I consent to the medical information included on this form being provided to Astraline in order to provide telecare services**  To be signed by the data subject if completed by them or in their presence;  where the data subject is incapable of this, the signatory confirms they have a legal basis for providing this information on their behalf | | | | | | | | | | | | | | | | | | Sign here | | | | | | | | | | | **Date:** |  |

Private and Confidential – For your protection all calls made to Astraline are recorded. The information on this form will only be used for the purposes of providing you with telecare services and communication with you and your nominated contacts about those services. This may include sharing information with the emergency services if required. It will be stored confidentially and securely in line with Data Protectiogislation.