

About the older person			
Name and surname:		ID number:	
Contact number:		Email:	

About the person who made contact (Source)			
Contacted by: (complete if not 'self')	Name:		Surname:
	Contact number:		Email:
	Relationship:		
	Organisation:		Role:
Date contact made:			
Type of assessment	New	Revision	Re-assessment
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Appeal
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk factors: Tick boxes to indicate which risks are applicable /present to inform the urgency of assessment			
Lives in bed	<input type="checkbox"/>	Oxygen dependency	<input type="checkbox"/>
Cognitive impairment with total incontinence	<input type="checkbox"/>	Chronic high-risk conditions requiring continuous nursing care	<input type="checkbox"/>
Domestic risk (gas, fire)	<input type="checkbox"/>	Risk of falling	<input type="checkbox"/>
Suspected /reported abuse (to self or by others)	<input type="checkbox"/>	Other	<input type="checkbox"/>

Is the Older Person aware of the initial contact?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes:	What is his/her perspective of the reason for the initial contact?			
If no:	Give reason, investigate and act accordingly:			
Older Person's opinion /perception of needs:				
Older Person agrees to assessment?:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If not, please give reasoning and outcome: (include risks and ability to make informed decision as applicable)				

Urgency of assessment?	Within 24 hours	<input type="checkbox"/>	Within 1 week	<input type="checkbox"/>	Within 1–3 weeks	<input type="checkbox"/>	Other	<input type="checkbox"/>
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Initial contact form completed by:	
Role:	
Date:	