





Lifeline and Telecare Referral Form

Date of referral received	Office use only
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Section 1: Referral Details – please complete if you are referring on someone’s behalf		
Name of the person completing the referral		
Relationship/Organisation		
Contact Number		
Email address		
Date referral completed		
Does the person consent to you making this referral on their behalf?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Please provide details of the person providing consent

Section 2: Your property		
Is the electric socket located on the same wall as the phone socket? <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Electric socket </div> <div style="text-align: center;">  Phone socket </div> </div>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are they easily accessible? If no, please ensure any obstructing furniture is moved before installation	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the phone socket no more than 2 meters away from the electric socket	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Who owns your property? Privately owned <input type="checkbox"/> Council <input type="checkbox"/> Housing association <input type="checkbox"/> Private landlord <input type="checkbox"/>		

Section 3: Referral	
Does this referral relate to a lifeline application only? If yes continue to complete section 4	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 4: Telecare referral	
Does this referral relate to telecare only? If yes continue to complete section 6	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a lifeline installed? If no, a lifeline needs to be installed for telecare equipment, please complete sections 5 & 6	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 5: Lifeline application			Office Use Only
Authority / Housing Association: DACORUM BOROUGH COUNCIL			
Category:			
Sender Name:		Email:	
Date Submitted:			
<i>I confirm that the persons named as emergency contacts, keyholders and doctors are aware that they have been named and that they agree with their name and contact details being stored and used by Dacorum Borough Council and Tunstall Response for this purpose.</i>		Signed: (Sender)	<input type="checkbox"/>
ID / Address Information			
Scheme ID:		Resident ID:	
Property Name:			
House Number:			
Street:			
Area:			
Town:			
County:			
Postcode:			
Telephone No:			<input type="checkbox"/>
Access / Equipment Information			
Is there a key safe fitted?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, what is the code?			
Location of the Key Safe:			
Telecare Installed:			

Smart Hub PRC Code & Serial Number:				<input type="checkbox"/>
First Resident Information				Office Use Only
Ms <input type="checkbox"/>		Miss <input type="checkbox"/>		
Mrs <input type="checkbox"/>		Mr <input type="checkbox"/>		
Dr <input type="checkbox"/>				
Forename:		Date of Birth:		
Surname:		Telephone Number:		
Known As:		Mobile Number:		<input type="checkbox"/>
Medical Information (Please only use the tick boxes provided and do not list any other conditions or medication as this will not be recorded.)				
KW1 - Sensory Impairments:		KW2 – Mental Health Disorder:		
Hearing Impaired	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	Alzheimers Disease
Sight Impaired	<input type="checkbox"/>	Blind	<input type="checkbox"/>	Dementia
Speech Impaired	<input type="checkbox"/>	No Verbal Communication	<input type="checkbox"/>	
KW3 - Language: If English is not the resident's first language, please indicate below;				
				<input type="checkbox"/>
GP Surgery				
Surgery Name:		Surgery Address:		
Surgery Tel No:		Post Code:		<input type="checkbox"/>
Carers Information				
Care Company:		Care Company:		
Tel Number:		Tel Number:		
Visit Times:		Visit Times:		<input type="checkbox"/>

Second Resident Information						Office Use Only
Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Mr <input type="checkbox"/> Dr <input type="checkbox"/>						
Forename:		Date of Birth:				
Surname:		Telephone Number:				
Known As:		Mobile Number:				<input type="checkbox"/>
Medical Information (Please only use the tick boxes provided and do not list any other conditions or medication as this will not be recorded.)						
KW1 - Sensory Impairments:			KW2 – Mental Health Disorder:			
Hearing Impaired	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	Alzheimers Disease	<input type="checkbox"/>	
Sight Impaired	<input type="checkbox"/>	Blind	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	
Speech Impaired	<input type="checkbox"/>	No Verbal Communication	<input type="checkbox"/>			
KW3 - Language: If English is not the resident's first language, please indicate below;						
						<input type="checkbox"/>
GP Surgery						
Surgery Name:		Surgery Address:				
Surgery Tel No:		Post Code:				<input type="checkbox"/>
Carers Information						
Care Company:		Care Company:				
Tel Number:		Tel Number:				
Visit Times:		Visit Times:				<input type="checkbox"/>

Resident Contact 1				
Key Holder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Next of Kin?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact Name:				
Address:				
Postcode:				
Home Tel No:				
Mobile Tel:				
Work Tel No:				
Relationship:				
				<input type="checkbox"/>
Resident Contact 2				
Key Holder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Next of Kin?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact Name:				
Address:				
Postcode:				
Home Tel No:				
Mobile Tel:				
Work Tel No:				
Relationship:				
				<input type="checkbox"/>
Resident Contact 3				
Key Holder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Next of Kin?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Contact Name:				
Address:				
Postcode:				
Home Tel No:				
Mobile Tel:				
Work Tel No:				
Relationship:				
				<input type="checkbox"/>

Section 6		
Risks		
Would the person's memory enable them to push a button?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would the person's manual dexterity enable them to push a button?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Are there any risks associated with Falls? If yes continue to fill out the information below	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How many times has the person fallen in the last three months?	Details	
The person has fallen due to seizures, dizziness or loss of consciousness	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Are there any significant risks associated with fire? If yes, please continue to fill out the information below		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes/No	If yes, please give details	
The person's behaviour and/or environment significantly increases risk of fire occurring	Yes <input type="checkbox"/> No <input type="checkbox"/>		
The person is unlikely to respond appropriately in the event of a fire	Yes <input type="checkbox"/> No <input type="checkbox"/>		
In the event of a fire the person would have difficulty evacuating the premises	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does anyone smoke within the property?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is there a working smoke detector in the property?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Are there any significant risks of carbon monoxide poisoning due to poorly maintained gas appliance(s)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would the person benefit from a carbon monoxide detector?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Are there any significant risks associated with flooding? If yes continue to fill out the information below		Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes/No	If yes, please give details	
The person has previously left taps running	Yes <input type="checkbox"/> No <input type="checkbox"/>		
There has been previous incidents of flooding	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Does the person have difficulty hearing the smoke alarm, telephone and doorbell?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the person forget to take their medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the person experienced domestic violence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the person experienced bogus callers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Does the person have needs that are more complex?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Please give details

Privacy statement

The information you give us will be held on council systems with appropriate security and access. The information we collect will be used for the purpose of setting up, monitoring and providing a community alarm service to enable you to summon help if needed. We may need to share this information with external health and social care professional's/providers who from time to time need to consult, in order to advise or provide you with the appropriate services.

Optional: We would also like to use your information for service planning, monitoring services and research. We will only do this if you tick the **YES** box below. If you do not agree to this – then please tick the **NO** box.

Yes No

More information on how the council use your personal data can be found here;

www.dacorum.gov.uk/privacypolicies

How did you hear about the service?

Please give details below

Please return application form to:

Supported Housing Service
Dacorum Borough Council
The Forum
Marlowes
Hemel Hempstead
Hertfordshire
HP1 1DN
Tel: 01442 228347
Email Lifeline@dacorum.gov.uk