West Lothian Council
Home Safety Service
Application Form (STRICTLY CONFIDENTIAL)

IF YOU ARE THE PERSON APPLYING FOR THIS SERVICE, PLEASE FILL IN SECTION A ONLY.
IF YOU ARE A PROFESSIONAL REFERRING A CLIENT PLEASE FILL IN SECTION A & B.

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK BOXES WHERE APPLICABLE.

OFFICE USE			
Ident No	Date Received	Screened By	Screened Priority

PART A – APPLICANT NEED COMPLETE PART A ONLY
Personal details

Surname	Forename(s)	Title	Date of Birth	Ethnicity
Applicant A				
Applicant B (spouse/partner)				

Address Postcode	Landline Telephone * Yes ☐ No ☐ Telephone Number (Including code) Telephone Provider BT / Cable Mobile telephone number
Does anyone else live at this address? Yes ☐ No ☐ If yes state others in house 1 ______ 2 ______ 3 ______	Do you have Broadband Yes ☐ No ☐ If yes, provider if known *Please note that a home landline telephone number is **essential** for this service

Accommodation

Flat	Ground Floor ☐	Do you use a Power Key	Yes ☐ No ☐
	Upper Floor ☐	Is the house difficult to find	Yes ☐ No ☐
Bungalow ☐		Special Instructions:-	
2 Storey House ☐			
Sheltered Housing ☐			
Heating	Gas ☐	Electricity ☐	Other ☐
Owner / Occupier ☐			
Private Landlord ☐	Name		Telephone No.
Housing Association ☐	Name		Telephone No.
West Lothian Council ☐			

CS6262 May 09

Next of kin

Name	Address (including Postcode)	Telephone no.		Relationship
		Home		
		Work		
		Mobile		

Key holders

Please list as many numbers as possible in order of preference, as this helps us respond

Name	Address (including Postcode)	Telephone no.		Relationship
1 -		Home		
		Work		
		Mobile		
2 -		Home		
		Work		
		Mobile		
3 -		Home		
		Work		
		Mobile		
4 -		Home		
		Work		
		Mobile		
5 -		Home		
		Work		
		Mobile		

General practitioner

Name	Address (including Postcode)	Telephone no.
Applicant A		
Applicant B		

Other information

State the reason why you have applied for the home safety service Please state how you found out about this service

About your health (Check all conditions that apply to you – please tick if they apply.)

	Applicant 1	Applicant 2		Applicant 1	Applicant 2
Cardio / vascular			**Medical conditions**		
Heart condition	☐	☐	Cancer		
Angina	☐	☐	Currently having treatment	☐	☐
Circulation problems	☐	☐	In remission	☐	☐
High blood pressure	☐	☐	Cured	☐	☐
Respiratory			Diabetes	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐
Bronchitis	☐	☐	Blood disorder	☐	☐
Breathing difficulties	☐	☐	Arthritis	☐	☐
Oxygen at home	☐	☐	Osteoporosis	☐	☐
Mind state			Speech Difficulties	☐	☐
Poor concentration	☐	☐	Allergies	☐	☐
Learning difficulties	☐	☐	Stroke/TIA	☐	☐
Memory loss	☐	☐	**Sensory**		
Anxiety	☐	☐	Blind/Partially sighted	☐	☐
Mental health problem	☐	☐	Profoundly deaf/Partial hearing	☐	☐
Mobility			Hearing aid	☐	☐
History of falls	☐	☐	Aids used (Detail)		
Details (recently?, how often, hospitalised?)					
Poor mobility	☐	☐			

Describe how your medical condition affects you (information you give us will help us to assess your priority for assessment)

Applicant's Signature	**Date:**

Data protection The information you provide on this form will be held / updated on a database to provide you with an appropriate response. We may on occasions share information with health professionals. We will not pass your details on to any other external company without your specific consent.

PART B – TO BE COMPLETED BY PROFESSIONAL REFERRING

Does the client have a history of falls?

Yes ☐ **No** ☐

If Yes, give details

Have there been any instances of flood/fire in the property?

Yes ☐ **No** ☐

If Yes, give details

Detail any health problems that may contribute to risk in the home

Detail any other risks the client has

Detail client's cognitive function / mental health

Are there any known risks to visiting staff?

Yes ☐ **No** ☐

If Yes, give details

Please detail any package of care that the client may have

	M	T	W	T	F	S	S		M	T	W	Th	F	S	S
Personal Care Provider _____ Times _____								District Nurse Name _____ Times _____							
Home Care Provider _____ Times _____								Family support Name _____ Times _____							
Day centre Name _____ Times _____								Neighbour support Name _____ Times _____							
Day hospital Name _____ Times								Shopping service							
								Appetito meals							

Does the client have an existing Community Alarm System?

Yes ☐ If yes do they have a pendant ☐ fall detector ☐ **or** pull cord ☐

No ☐ Name of provider (if known)

Is the client in agreement with this referral? Yes ☐ No ☐

Referrer's Name	Base	Designation	Telephone No.

Referrer's Signature **Date:**

Home Safety Service Team
Lomond House
Beveridge Square
Livingston, EH54 5QF
Telephone 01506 771770

Please note that all calls to the response centre are recorded