

Name:	Main ID:	Completed by:
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FACE Background Information Form v.6

Confidential

Background information & referral details can be collected directly from the person or from someone else on their behalf

Family name		Given name		Title	
Preferred name		Date of birth		Age	
NHS Number		Social care ID			
Gender		Preferred language			
Ethnicity		Employment status			
Religion		Current phone number			
Current address	Postcode:	Mobile phone number			
		Email address			
Permanent address (if different)	Postcode:	Accommodation type			
		Accommodation tenure			
Lives with					
Contact and visit details					

Alerts

Known risks to self		Special dietary needs	
Known risks to others		Communication support	
Allergies		Advocate required	
Recent/risk of infection		Mental capacity needs	
Risk of falls		Advance decision made	

Referral details *(If self-referral address will be assumed to be as above. If in hospital identify person's ward)*

Referral date		Referral time		Location at referral	
Referral method				Referral type	
Referrer name				Referrer role	
Referrer address (e.g. hospital)	Postcode:			Referrer email	
				Referrer telephone no	
Reason for referral <i>(identify reason type right then detail)</i>					

Details:

Is the client aware of the referral? If no why not?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Details:

Date of first contact <i>(with trained staff member)</i>		Time of first contact	
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Next of kin	Main carer	Other
Relationship	Relationship	Relationship
Tel no	Tel no	Tel no
Address	Address	Address

GP	Consultant	Key worker
Practice	Title	Role
Tel no	Tel no	Tel no

Dependents	Partner	<input type="checkbox"/>	Children	<input type="checkbox"/>	Other adults	<input type="checkbox"/>	Pets	<input type="checkbox"/>
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Details:

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FACE Contact Assessment v.6			Confidential
<i>To be completed with the person and/or advocate on person's behalf</i>			
Your main current difficulties and concerns <i>(including perceived impact on life and relevant personal history)</i>			
Details:			
Have there been any important recent events or changes in your life?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:			
How you would like your situation to improve			
Details:			
Your family or carer(s) or advocate's views of your situation and what would improve it			
Details:			
Do you have any other difficulties or concerns? <i>(complete other domains as indicated)</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If straightforward enquiry, need for aids/equipment only and/or no indication of requirement for holistic assessment go to Next steps and actions on p.4</i>			
Your day-to-day activities <i>(e.g. shopping, laundry, cleaning) (optional)</i>		Problem/need reported	<input type="checkbox"/>
Details:			
Your personal care <i>(e.g. dressing, washing, toileting) (optional)</i>		Problem/need reported	<input type="checkbox"/>
How often do you need help with your personal care? <i>(per week)</i>			
Details:			
Your mobility <i>(e.g. getting out and about, falls, transfers) (optional)</i>		Problem/need reported	<input type="checkbox"/>
Details:			
Your home and living situation <i>(optional)</i>		Problem/need reported	<input type="checkbox"/>
Details:			
Your physical health and well-being <i>(optional)</i>		Problem/need reported	<input type="checkbox"/>
Details:			
Disabilities, impairments or health conditions <i>(note relevant medical history)</i>			
Main condition/disability		Details:	
Additional condition 1			
Additional condition 2			
Relevant medical history			
Details:			

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Findings of recent observations, screening, tests or investigations			Yes	<input type="checkbox"/>	None	<input type="checkbox"/>
Details:						
Medication <i>(relating to physical or mental health problems) (optional)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Your finances <i>(optional)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Your relationships and social activities <i>(optional)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Your involvement in work, training or education <i>(optional)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Your emotional well-being and mental health <i>(optional)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Safety and risk <i>(consider any safeguarding adults issues)</i>			Problem/need reported		<input type="checkbox"/>	
Details:						
Current support <i>(support received at time of referral)</i>						
Do you receive support from family, friends or other local people?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Details:						
Do you receive support from social care or health care services?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Details:						
Have you specific care or support preferences? <i>(Consider cultural & spiritual preferences)</i>			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Details:						
About how much additional support do you need at present?						
Details:						
Is your need for support likely to be temporary? <i>(e.g. brief illness, carer absent)</i>			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Details:						

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Summary of Your Needs and the Outcomes You Wish to Achieve

Domain	Your needs	Outcomes you wish to achieve

Highest level of need/risk (FACS)	None	<input type="checkbox"/>	Low	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Substantial	<input type="checkbox"/>	Critical	<input type="checkbox"/>
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Does eligibility for NHS continuing care require consideration? (if so use checklist)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Next steps (note actions already undertaken)

Information & advice	<input type="checkbox"/>	
Referral(s)	<input type="checkbox"/>	
Tests/investigations	<input type="checkbox"/>	
Equipment/adaptations	<input type="checkbox"/>	
Telecare/telehealth	<input type="checkbox"/>	
Re-ablement/rehab	<input type="checkbox"/>	
Crisis support	<input type="checkbox"/>	
Further assessment	<input type="checkbox"/>	
Other actions	<input type="checkbox"/>	

Primary client category (social services only)	
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Does mental capacity or deprivation of liberty need further consideration?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Details:

I agree that this assessment may be shared as needed to support my care:

Yes	<input type="checkbox"/>	Yes, but with limitations	<input type="checkbox"/>	No	<input type="checkbox"/>	Unable to consent	<input type="checkbox"/>
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Details of any limitations:

Your signature		Date		Signature of your advocate or proxy		Date	
Assessor's signature		Date		Proxy telephone number			
Authorised by signature		Date		Source of proxy authorisation			
Completed by				Contact details (tel)			
Role/profession				Care/support team			