



MEALS
ON
WHEELS

PRYD
AR
GLUD

24/7 SERVICES REFERRAL FORM

Please take the time to complete this form for either one or both services offered by '24/7 Services'.

Pick tick the service the referral is for:

Telecare Meals on Wheels Both

Care First No (if applicable):

Date of referral:

Section 1 Your Details

Name:

Team:

Telephone:

Email:

Section 2 Customer Details

Name:

Date of Birth:

Address:

Telephone number:

Mobile number:

Section 3 GP Surgery Details

Name of Surgery:

Address:

GP Name:

Tel:

Section 4 Social Worker/Carer Details **NB: If no S/W refer to FPOC for wellbeing assessment.**

Name of Social Worker/Care Agency:

Reason for referral:

Address:

Telephone:



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Section 5 Property Details

Property type: Keysafe No:

Property is: Council Private Housing Association

Do you have a pet living at the property? Yes No

If yes, have there been any issues with visitors to the property? (Please give details)

Section 6 Next of Kin

Please confirm details of next of kin and/or contacts we can call in the event of an emergency.

Contact 1.

First Name: Surname:

Address:

Relationship: Postcode:

Mobile tel No: Home tel No:

Contact 2.

First Name: Surname:

Address:

Relationship: Postcode:

Mobile tel No: Home tel No:

Contact 3.

First Name: Surname:

Address:

Relationship: Postcode:

Mobile tel No: Home tel No:



Section 7

Meals on Wheels Service Required (MEALS ON WHEELS ONLY)

Please tick which days Meals on Wheels is required:

Monday Tuesday Wednesday Thursday Friday

Saturday Sunday

Are there dietary needs:

Normal Diabetic Vegetarian Soft Diet Halal

Other (Please give details)

Dietary Preferences: (Please note any dislikes)

Is the customer able to heat a frozen meal supplied by Meals on wheels should the team be unable to deliver a hot meal (e.g due to extreme weather) Yes No

Section 7b

Payment Details (MEALS ON WHEELS ONLY)

Invoices will be issued on a four weekly basis for the cost of the meals, please provide the below details if payment is to be made via Direct Debit.

Name of person making payment:

Billing Address:

Contact Number: Relationship to customer:

Section 8

Telecare Sensors Required (TELECARE ONLY)

Would you like our Telecare Officer to arrange a site visit prior to installing? Yes No

Please tick which sensors are required.

Smoke Detector Flood Detector CO Detector Fall Detector

Bogus Caller Pressure Mat Temp Extreme DDA Pager

Epilepsy Sensor Bed Occupancy Property Exit Keysafe

Chair Occupancy PIR Monitor Other? (Please note below)