



**PLEASE COMPLETE THIS FORM USING CAPITALS AND BLACK INK**

**LifeLine  
Community Alarm and Telecare Referral Form**

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**Please ensure this form is completed in full. Any missed information will result in the referral being sent back.**

Please be aware that there will be a £3.50 weekly charge for Community Alarm and £3.50 weekly charge for Telecare. If the client states they may have difficulty paying then a financial assessment may be offered.

| Referral completed by:                                                                        |  |                          |  |
|-----------------------------------------------------------------------------------------------|--|--------------------------|--|
| Name                                                                                          |  |                          |  |
| Address:                                                                                      |  |                          |  |
| Telephone:                                                                                    |  |                          |  |
| Email:                                                                                        |  |                          |  |
| Relationship to client:                                                                       |  |                          |  |
| Is this referral for the purpose of                                                           |  |                          |  |
| 1 - End of life care                                                                          |  |                          |  |
| 2 - Supporting hospital discharge                                                             |  | Discharge Date           |  |
| 3 - Preventing hospital admission                                                             |  |                          |  |
| 4 - Rehab/enablement                                                                          |  |                          |  |
| 5 - Other                                                                                     |  |                          |  |
| CLIENT DETAILS                                                                                |  |                          |  |
| Name:                                                                                         |  | CareFirst ID:            |  |
| Date of Birth:                                                                                |  | Marital Status:          |  |
| Address:                                                                                      |  | Postcode:                |  |
| Home Telephone Number:                                                                        |  | Home Telephone Provider: |  |
| CAS REFERRAL PLEASE NOTE – IF THERE IS NO LANDLINE A SIM CARD MUST BE SUPPLIED BY THE CLIENT. |  |                          |  |
| Mobile Telephone Number:                                                                      |  |                          |  |
| Email:                                                                                        |  |                          |  |



| <b>GP PRACTICE</b>                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Practice Name:</b>                                                                                                                       |  |
| <b>Practice Address:</b>                                                                                                                    |  |
| <b>Practice Telephone Number:</b>                                                                                                           |  |
| <b>Registered Doctor:</b>                                                                                                                   |  |
| <b>Please detail any health/medical/mobility issues:</b>                                                                                    |  |
|                                                                                                                                             |  |
|                                                                                                                                             |  |
|                                                                                                                                             |  |
|                                                                                                                                             |  |
| <b>PROPERTY DETAILS</b>                                                                                                                     |  |
| <b>ALL QUESTIONS BEOW MUST BE ANSWERED.</b>                                                                                                 |  |
| <b>FAILURE TO DO SO WILL DELAY ANY INSTALLATION</b>                                                                                         |  |
| <b>Does the property have an active internet account and connected router?</b>                                                              |  |
| <b>Is there a key safe fitted at the property?</b>                                                                                          |  |
| <b>If yes, please note the key safe number:</b>                                                                                             |  |
| <b>Is there a 13amp power socket within 1.5m (5ft) of the telephone point, which can be reached without crossing a doorway/hallway etc?</b> |  |
| <b>Is there a smoke alarm in the property?</b>                                                                                              |  |
| <b>How many bedrooms are in the property</b>                                                                                                |  |
| <b>Please state the type of house eg bungalow/flat:</b>                                                                                     |  |
| <b>Is the property owned by the client?</b>                                                                                                 |  |
| <b>If the property is rented, please state who the landlord is:</b>                                                                         |  |
| <b>Please list name/s and relationship to the client of anyone else living in the property:</b>                                             |  |
| <b>Are there any problems/hazards relating to property access?</b>                                                                          |  |

| <b>EQUIPMENT BEING REQUESTED</b>                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Please detail who is to be contacted to arrange the installation of equipment:</b>                                                                    |  |
| <b>Community Alarm:</b><br>This is the basic button and box                                                                                              |  |
| <b>TELECARE (detail below)</b>                                                                                                                           |  |
| <b>Smoke detector</b>                                                                                                                                    |  |
| <b>Temperature Extremes sensor</b>                                                                                                                       |  |
| <b>Vibrating Pillow alert / DDA pager</b><br>(Consists of DDA Pager or Wrist Pager and/or Pillow Alert and/or Teletransmitter)                           |  |
| <b>Flood detector</b>                                                                                                                                    |  |
| <b>Carbon Monoxide detector</b>                                                                                                                          |  |
| <b>Bed Occupancy sensor*</b> (Consists of Bed Sensor & Bed Tim)                                                                                          |  |
| <b>Link bed occupancy sensor to bedside lamp</b> (Consists of Main Controller and/or Lamp Module, also needs to be in the same room as occupancy sensor) |  |
| <b>Chair Occupancy sensor*</b> (Consists of Chair Sensor & Chair Tim)                                                                                    |  |
| <b>PIR Movement sensor*</b> (There are two either Standard or Fast)                                                                                      |  |
| <b>Property Exit sensor*</b> (Consists of PES PIR and PES Tim)                                                                                           |  |
| <b>Fall Detector</b>                                                                                                                                     |  |
| <b>Epilepsy Sensor</b> (Consists of ROM and Sensor)                                                                                                      |  |
| <b>Other</b> (specify)                                                                                                                                   |  |



**EMERGENCY CONTACTS**  
**(Must be physically able to attend call outs)**

**Main Contact:**

|                                                   |  |
|---------------------------------------------------|--|
| <b>Name:</b>                                      |  |
| <b>Relationship to Client:</b>                    |  |
| <b>Address:</b>                                   |  |
| <b>Home Telephone Number:</b>                     |  |
| <b>Mobile Telephone Number :</b>                  |  |
| <b>Work Telephone Number:</b>                     |  |
| <b>Email Address:</b>                             |  |
| <b>Is this contact a Key Holder:</b>              |  |
| <b>Is this contact more than 30 minutes away?</b> |  |

**Contact 2:**

|                                                   |  |
|---------------------------------------------------|--|
| <b>Name:</b>                                      |  |
| <b>Relationship to Client:</b>                    |  |
| <b>Address:</b>                                   |  |
| <b>Home Telephone Number:</b>                     |  |
| <b>Mobile Telephone Number:</b>                   |  |
| <b>Work Telephone Number:</b>                     |  |
| <b>Email Address:</b>                             |  |
| <b>Is this contact a Key Holder:</b>              |  |
| <b>Is this contact more than 30 minutes away?</b> |  |

**Contact 3:**

|                                                   |  |
|---------------------------------------------------|--|
| <b>Name:</b>                                      |  |
| <b>Relationship to Client:</b>                    |  |
| <b>Address:</b>                                   |  |
| <b>Home Telephone Number:</b>                     |  |
| <b>Mobile Telephone Number:</b>                   |  |
| <b>Work Telephone Number:</b>                     |  |
| <b>Email Address:</b>                             |  |
| <b>Is this contact a Key Holder:</b>              |  |
| <b>Is this contact more than 30 minutes away?</b> |  |



**NEXT OF KIN:**

|                                 |  |
|---------------------------------|--|
| <b>Name:</b>                    |  |
| <b>Relationship to Client:</b>  |  |
| <b>Address:</b>                 |  |
| <b>Home Telephone Number:</b>   |  |
| <b>Mobile Telephone Number:</b> |  |
| <b>Work Telephone Number:</b>   |  |
| <b>Email Address:</b>           |  |

Please email completed form to [jointequipmentcentre@aberdeenshire.gov.uk](mailto:jointequipmentcentre@aberdeenshire.gov.uk) or post to the Joint Equipment Centre, Burghmuir Place, Inverurie, AB51 4FW. Telephone 01467 536161 for further assistance.