Official Use Only Date Issued: …………………. SWIFT Number: ………………

ISLE OF WIGHT COUNCIL

Social Services request for Occupational Therapy Services

SELF REFERRAL FORM

Please provide information or circle the correct answer

Title: Mr/Mrs/Miss/Ms	GP:
Surname:	Address:
First Name:	
Date of Birth:	Tel No:
Address: Postcode: Tel No:	Consultant: District Nurse: Care Manager: Other Professional:
	Your Nationality:
Do you live alone? **YES/NO** If **NO**, who with?	
Do you have a disability or long-term medical condition: **YES/NO** If **YES,** please give details, including **how long** you have had difficulties for:	
Do you have a carer? **YES/NO** If **YES**, who?	
Does the person you live with have a disability or long term medical condition? **YES/NO**, If **YES**, please describe.	
Are you a permanent wheelchair user? **YES/NO**	
Have you fallen recently? **YES/NO** WHEN? If **YES**, WHERE?	

Let us know which activities are difficult for you and which you can manage.
Please TICK the column that applies to you most.

	Able to do	Able to do – with help from another person	Able to do – with equipment	Have difficulty doing	Unable to do
Walking indoors					
Up/downstairs indoors					
Outdoor steps/stairs					
Using wheelchair indoors					
Using wheelchair outdoors					
Getting to the toilet					
Getting on/off the toilet					
Getting to your bed					
Getting in/out of bed					
Getting in/out of a chair					
Getting washed					
Getting in/out of bath					
Using over-bath shower					
Using walk-in shower					
Getting dressed					
Cooking/kitchen					
Eating/drinking					
General household jobs					
Shopping					
Laundry					
Writing					
Speaking					
Answering the door					
Using the telephone					
Other – please specify					

PROPERTY DETAILS
Please provide information or CIRCLE the correct answer:-

1. **Type of accommodation,** eg. bungalow, terrace house, flat etc.

   …………………………………………………………………………

2. **Who owns the property?**

Yourself or your family - Private Rent - Housing Association

If Housing, which? SWHA MEDINA VECTIS

Other: ……………………………………………………………..

3. **Which rooms do you have? Please CIRCLE all that apply.**

Kitchen Kitchen/Diner Dining Room
Lounge/Diner Lounge

Bathroom: Same floor Downstairs Upstairs Both

Toilet: Same floor Downstairs Upstairs Both

Bedrooms: 1 2 3 4

Other (Please specify)…………………………………………….

Stairs: Straight Curved

Stair rails: None One Side Both sides

BENEFITS RECEIVED **Please CIRCLE all that apply**

Income Support Housing Benefit Council Tax Benefit

Attendance Allowance - High/Low

Disability Living Allowance - Care - High/Middle/Low

- Mobility - High/Low

Other………………………………………………………………………

1. **Do you have any equipment or rails already? Please specify.**

2. **What help do you now require from Social Services?**

Thank you for taking the time to complete this form, which will help us to ensure that your case is dealt with as efficiently as possible.

Please be advised that all information provided will be dealt with in a confidential manner.

If you would like this document translated or in a different format, please contact us on 01983 534520

Signature:……………………………Date:………………………..

Please return the completed form to:

Occupational Therapy Department
St Mary's Hospital
Newport
Isle of Wight
PO30 5TG
Tele: 01983 534520
Fax: 01983 552052

For I.O.W.C Use Only

Outcome: ____________________

Date: ____________________

Signed: ____________________