CARE SOLUTIONS UK LTD

REGISTRATION FORM

NAME OF CLIENT:	
Address:	TEL:
	FAX:
	E-mail:

NAME OF CONTACT:	
Relationship to client:	
Address:	TEL:
	FAX:
	E-mail:

NEXT OF KIN (if different from contact):	
Relationship to client:	
Address:	TEL:
	EMAIL:

TYPE OF HELP:

FROM:	**TO:**

DOCTOR:	TEL:

INVOICES TO:	
Relationship to client:	
Address:	TEL:
	E-mail:

Please make sure you have adequate insurance to cover a temporary worker, household insurance and vehicle insurance if needed. **Accept** ☐

Client Date of Birth:
Physical History/Condition:
Mental History/Condition:

Qualities and experience expected from helper:

Must the helper be a non-smoker?
Yes □ No □ Don't mind □

Must the helper be able to drive?
Yes □ No □
IF YES, will you provide a car?
Yes □ No □
If yes, what type of car?
Auto □ Manual □

Company/Pastimes

Does the Client:
Enjoy the companionship of a carer? □
Prefer to remain alone? □
Enjoy specific interests/hobbies?

HELP REQUIRED:

Getting up: Yes □ No □

Going to bed: Yes □ No □

Washing: Yes □ No □

Bathing: Yes □ No □

Showering: Yes □ No □

Dressing/undressing: Yes □ No □

Is the client mobile: Yes □ No □

IF YES, aids required:
Sticks □ Zimmer □ Wheelchair □

Assistance Required
Minimal □ One person □ Two people □

Transferring: Yes □ No □

IF YES, aids required:
Glide sheet/board □ Hoist □

Assistance Required
Minimal □ One person □ Two people □

Help to loo/commode: Yes □ No □

Assistance Required
Prompt □ One person □ Two people □
Commode □ Day □ Night □

Financial
Arrangements for housekeeping money, keeping log of all cash expenses, payments of bills, collection of pension, etc by the Carer on behalf of the Client in place?
Will the log book be checked by the Client/Client's Representative? Yes □ No □

Type of residence:
House □ Flat □ Bungalow □
Other……………………………

Public Transport available?

HOUSEKEEPING:
Are the shops near? Yes □ No □

Shopping arrangements if not:

Do you have a cleaner/gardener?
Cleaner: Yes □ No □
If yes, how often? ………..
Gardener: Yes □ No □
If yes, how often? …………

Please state how much help you require with the laundry.

Any other household arrangements:

Incontinence: Yes □ No □

IF YES, aids required:
Pads □ Condom Drainage □
Catheter □

Night care:

Independent □ Help 1-2 times □
Help 3-4 times □ Night care □

Help required for:
Toilet □ Drink □ Reassurance □
Other:

Sleep:
Morning: Waking Time……………
Getting up Time………..

Night: At what time does the Client
Prepare for bed………..
Retire for the night……..

Diet preferred:

Normal □ Soft □ Vegetarian □
Special:.......................................
Allergies (if any):...........................

Medication

Self-administered□
Assistance required □

By signing the form or clicking the Accept button you confirm that you have read, understood and accept our Terms of Business and agree to comply with its content. Please note that you are consenting to Live-in Care. Carers should be paid weekly and the agency fee should be paid monthly and are not negotiable.

………………………………………… **Sign / Accept** □