|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | |  | | | **Date** | | |  | | |  |  | |  |  | |
|  | | |  | | | **DD** | | |  | **MM** | |  | **YYYY** | |
| **Warm and Well Reference:**  **(NEA use only)** |  | | | | **GDPR Consent for Referral Given:** | | | | | | | Yes | | | No | | | |
| **Client Details** | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | | | | | | | |
| **Address (Incl Postcode):** | |  | | | | | | | | | | | | | | | | |
| **Date of Birth:** | |  | | | | | | | | | | | | | | | | |
| **Telephone Number:** | |  | | | | | | | | | | | | | | | | |
| **Email Address:** | |  | | | | | | | | | | | | | | | | |
| **Gender:** | | Male | | | |  | | Female | | | | | | | | | |  |
| **Health & Well Being** | | | | | | | | | | | | | | | | | | |
| **Has your client received the Flu jab this year?** | | | Yes | | | | | |  | | No | | | | | | |  |
| **Have they a Respiratory health condition? please give details:** | | | COPD | | | | | |  | | **Notes:** | | | | | | | |
| Asthma | | | | | |  | |
| Other Respiratory | | | | | |  | |
| None | | | | | |  | |
| **Have they a Cardiovascular health condition? please give details:** | | | Heart condition | | | | | |  | | **Notes:** | | | | | | | |
| Angina | | | | | |  | |
| Diabetes | | | | | |  | |
| Other cardiovascular | | | | | |  | |
| None | | | | | |  | |
| **Do they suffer from a Mental health condition? please give details:** | | | Depression | | | | | |  | | **Notes:** | | | | | | | |
| Anxiety | | | | | |  | |
| Other mental health | | | | | |  | |
| None | | | | | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Do they have any other chronic condition?** **please give details:** | | | Yes | | | | |  | | | **Notes:** | | | | |
| No` | | | | |  | | |
| **Do they have a disability?** | | | Mobility problems | | | | |  | | | **Blue Badge Holder?** | | | | |
|  | | | Other Disability | | | | |  | | | Yes | | |  | |
|  | | | None | | | | |  | | | No | | |  | |
| **Is client pregnant?** | | | Yes | |  | | No |  | | N/A | | | |  | |
| **Have they recently had any falls resulting in a hospital stay?** | | | Yes | | | | |  | | No | | | |  | |
| **Household** | | | | | | | | | | | | | | | |
| **Housing Status:** | | Owner Occupier | | Private Tenant | | Social Housing | | | Co-Ownership Housing | | | Temporary  Accommo-dation | Other | |
|  | |  | |  | | |  | | |  |  | |
| **Household Heating:** | | Oil | | Gas | | E7 | | | Solid Fuel | | | LPG | Other | |
|  | |  | |  | | |  | | |  |  | |
| **Approximate Income:** | | Under £10,000 | | Under  £15,000 | | Under  £20,000 | | | Under  £25,000 | | | Under  £30,000 | Under  £35,000 | |
|  | |  | |  | | |  | | |  |  | |
| **Benefit Details: Please list** | |  | | | | | | | | | | | | |
| **Information** | | | | | | | | | | | | | | | |
| **Reason for referral?**  **Client status? (e.g. married/single/cohabiting with or without children)** |  | | | | | | | | | | | | | | |
| **Other agency involvement:** |  | | | | | | | | | | | | | | |
| **NEA NI Date contacted:** |  | | | | | | | | | | | | | | |
| ***PLEASE RETURN COMPLETED FORMS TO:*** [***warmandwell@nea.org.uk***](mailto:warmandwell@nea.org.uk) | | | | | | | | | | | | | | | |