CLIENT / CARE USER ENQUIRY FORM

Gilgal Home Care & Training Services

For Families, Representatives & Care Users

Purpose of This Form

This form helps Gilgal Home Care & Training Services understand your care needs so we can arrange the right support for you or your loved one. All information shared is treated confidentially in line with our Privacy Policy.

SECTION 1: DETAILS OF PERSON REQUIRING CARE

Full Name: _____
Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Prefer not to say

Home Address:

Current Living Arrangement:
☐ Lives alone ☐ Lives with family ☐ Lives with carer ☐ Other _____

SECTION 2: FAMILY MEMBER / REPRESENTATIVE DETAILS

Full Name: _____
Relationship to Care User: _____

Address (if different):

Phone Number: _____
WhatsApp Number: _____
Email Address: _____

Are you the main decision-maker for care? ☐ Yes ☐ No

SECTION 3: CARE & SUPPORT NEEDS

Please tick all that apply:

☐ Personal care (washing, dressing, toileting)
☐ Companionship & emotional support

☐ Medication reminders
☐ Meal preparation & nutrition support
☐ Mobility & moving support
☐ Stroke aftercare / rehabilitation support
☐ Dementia or memory support
☐ Hospital discharge support
☐ Overnight or sleep-in care
☐ Long-term ongoing care
☐ Short-term or respite care
☐ Adult social care on behalf of family
☐ Other (please specify): _____

SECTION 4: HEALTH & WELLBEING INFORMATION

Does the care user have any of the following? (Tick if applicable)

☐ Stroke
☐ Dementia / Memory problems
☐ Diabetes
☐ Mobility difficulties / falls risk
☐ Mental health needs
☐ Long-term illness
☐ Other health conditions (please specify):

Is the care user currently receiving hospital or medical treatment? ☐ Yes ☐ No

---

SECTION 5: HOSPITAL DISCHARGE (Clinically Optimised Patients)

This section is to be completed where the referral is linked to a hospital discharge.

Name of Hospital / Health Facility: _____
Discharging Department / Ward: _____
Hospital Contact Person (if applicable): _____
Contact Number / Email: _____

Has the patient been declared *clinically optimised for discharge*? ☐ Yes ☐ No ☐ Pending

Primary reason for hospital admission:

Post-discharge support required (tick all that apply): ☐ Personal care support
☐ Stroke aftercare / rehabilitation
☐ Mobility & falls prevention

☐ Medication reminders
☐ Equipment support at home
☐ Adult social care support
☐ Short-term reablement
☐ Long-term ongoing care

Expected discharge date (if known): _____

SECTION 6: PREFERRED CARE ARRANGEMENTS

Preferred Start Date: _____

Preferred Care Schedule:
☐ Daytime support ☐ Overnight care ☐ Live-in care ☐ Flexible / to be discussed

---

SECTION 6: SAFETY & HOME INFORMATION

Are there any known risks we should be aware of? (e.g. falls, mobility, pets, access issues)

SECTION 7: CONSENT, CONFIDENTIALITY & DATA SHARING

Consent for Private Clients & Family Representatives

☐ I confirm that I am the care user or a legally authorised family member / representative.

☐ I give my consent for Gilgal Home Care & Training Services to collect, store, and process personal and health-related information for the purpose of providing care, assessment, care coordination, and related services.

☐ I understand that my information will be handled confidentially and in line with the Nigeria Data Protection Act (NDPA) 2023 and Gilgal's Privacy Policy.

Consent & Data Sharing for Hospital Discharge Referrals

(For hospital-led or joint referrals only)

☐ I consent to Gilgal Home Care & Training Services sharing relevant information with hospital discharge teams, healthcare professionals, therapists, and social care professionals involved in the care and safe discharge of the patient.

☐ I understand that information may be shared without consent where required for safeguarding, legal obligations, or