**Carers Emergency Plan**

**Having a plan in place can help ease your worries if you're not able to care for the person you look after at any point in the future. Make sure you let your emergency contacts know where to find the information and keep their contacts handy so you or someone else can get in touch with them.**

# **About you**

|  |  |
| --- | --- |
| **Your Name** |  |
| **Preferred name** |  |
| **Your Address** |  |
| **Postcode** |  |
| **Your phone number** |  |
| **Emergency Contact details including name, phone number and relationship to you** |  |
| **Next of kin** |  |
| **Details of caring role** | **How many hours a week do you provide care?**  0 - 7hrs  8 - 24hrs  25 - 35hrs  36 – 50hrs  24/7  **Do you provide:**  *Mark all that apply.*  Emotional support: listening and talking.  Household chores: cleaning, cooking, washing, ironing, or shopping.  Medication support: picking up medication, reminding about medication or physically helping someone with tablets or creams.  Personal care: eating, getting to the toilet, washing, and dressing.  Physical care: mobility support around their home. Administrative support: help with appointments and documentation.  Caring at a distance: providing support and contact to someone in secure services.  **Other, please detail:** |

# **About the person you care for**

|  |  |
| --- | --- |
| **Their Name** |  |
| **Preferred name** |  |
| **Their Address (if different from above)** |  |
| **Postcode** |  |
| **Their phone number** |  |
| **Emergency contact details** *(Other than you, please give relationship to cared for person)* |  |
| **Next of kin and relationship to cared for person** |  |

|  |  |
| --- | --- |
| **Diagnosis** | *Mark all that apply.*  Dementia/Alzheimer’s  Learning Disability  Autism spectrum  Physical disability  Mental Health  Elderly and/or frail  Other please specify below: |
| **Communication needs such as hard of hearing, language barrier**  **All other sensory needs** | *Mark all that apply.*  Hearing impairment  Sight impairment  Other language  *Please specify language below:*  Other sensory needs  *Please specify below:* |
| **Please tell us briefly the care needed so this person can remain at home,** *(i.e. what help they need from you)* |  |
| **Mobility issues and walking aids used**  (Transfer means being able to safely sit up from lying position or stand up from a sitting position) | **Can the person you care for:**  *Mark all that apply.*  Transfer independently.  Requires support for transfer.  Cannot transfer without support.  **Equipment used e.g., hoist, walking frame, wheelchair.**  Yes  No  Please specify what equipment is used if any below: |
| **Any dietary requirements or allergies** | Yes  No  Details below: |
| **Details of medical conditions**  **Please tell us where the cared for persons current medication is kept**  **Where is repeat prescription form kept?** *(Please ensure this is completed so we have details of the medication)* |  |
| **Any other regular or ongoing treatment**  *(Hospital or GP visits etc)* |  |
| **How to access the property**  *(Key safe details, who holds a spare key; are there any pets? etc)* | Key Safe – code:  Spare Key – held by:  Pets – please give details: |
| **Their GP details**  *(Including phone number)* |  |
| **Their hospital specialists**  *(If applicable) including phone number* |  |
| **Their paid care providers**  *(If applicable) including phone number* |  |

# **Emergency contacts**

Details of people who could assist in an emergency. If you feel there is nobody you could call on in an emergency, Shropshire Council’s First Point of Contact team can be called on to support if you are registered on the database. Contact number: 0345 678 9044.

|  |  |
| --- | --- |
| **Name and relationship to you both** | **Contact number** |
|  |  |
|  |  |

# **Other important information**

☐ Health and Welfare Power of Attorney for the person I care for held by:

☐ Property and financial affairs Power of Attorney for the person I care for held by:

☐ Court of protection deputy(s) for the person I care for are:

☐ An advance directive has been made. If ticked, please give details:

Any other information you feel may be useful:

**Consent**

# **We give our consent for our details, collected on this emergency plan, to be held on Shropshire Council’s database for use should an emergency situation arise.**

**Signed:** Carer……………………………………………..

**Signed:** Person with care needs…………………………..

# **Shropshire Council Adult Social Care First Point of Contact details:**

Office hours: **0345 678 9044**

*Mon-Thurs 8-45am -5-00pm Fri 8-45am to 4-00pm*

Out of hours: **0345 678 9040**

**Remember to check and update the details on this plan regularly.**

You can get more details and copies of this form [online](https://www.shropshire.gov.uk/shropshire-choices/caring-for-someone-else/carers-register/) or by contacting Shropshire Carers team on 01743 341995 or email: [Shropshire.Carers@shropshire.gov.uk](mailto:Shropshire.Carers@shropshire.gov.uk)

Please give a copy of this plan to your chosen contacts and to Shropshire Carers Support team either by email: [Shropshire.carers@shropshire.gov.uk](mailto:Shropshire.carers@shropshire.gov.uk) or post to: Community Partnership Team, The Guildhall, Frankwell Quay, Shrewsbury SY3 8HB

**For office use**

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| **LAS No** |  |