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**INITIAL CONSULTATION – FREQUENT USERS OF HEALTH CARE PROVISION**

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| **Contact Details**  Name:  Address:  Post Code:  DOB:  Tel: | **Number of Contacts with**  WAST:  Emergency Unit:  Out of Hours GP Service:  Over what period of time: | **Appointment Date**  **In attendance:** |
| **Reasons for Contacts**  Presenting Complaints  Patients perception of triggers  Motivation for contacts  Intended primary/secondary gain  Does patient feel their routine healthcare providers adequately meet their needs?  Patients perception of desired changes/improvements to care provision |  | |
| **Physical Wellbeing**  Diagnosis  Medication  Alcohol – current/historical  Smoking - current/historical  Drugs - current/historical |  | |
| **Spiritual Wellbeing**  Religion/Faith/Spirituality  Do they attend/wish to attend a faith based group – church, chapel, temple, synagogue, mosque etc |  | |
| **Mental Wellbeing**  Stress  Esteem  Confidence  Concerns  Risk Issues  Trigger Factors |  | |
| **Social Situation**  Support/significant others  Housing – rented, private, council etc  Dependents  Carers  Pets in house  Hobbies/Interests |  | |
| **Financial Considerations**  Employment  Education  Debt  Food poverty  Child care considerations |  | |

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| **Individual’s priority goal – what matters most?** | **Planned action toward realising that goal from current reality** | **Options support/referral required** | **What does the patient consider to be barriers to this?** |
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| **Additional Information – add any safeguarding concerns (document relevant referrals), cultural considerations, risk factors for future care provision with external agencies** |

**I give permission that allows for the information recorded on this form to be stored and used for the purposes of providing services to me and my family and for the monitoring the impact of the Frequent Attender Service. I understand that the information will be shared with agencies that are able to provide support, in order to ensure that the appropriate support is accessed**

**I give/do not give permission (delete as applicable) for my information to be anonymised and used for the purposes of producing case studies to promote the work of services**

**PRINT NAME……………………………………………………………………………………. SIGNATURE………………………………………………………………………………………**

**WELL BEING SCALE – TO BE COMPLETED AT INITIAL ASSESSMENT & PRE DISCHARGE FROM FREQUENT ATTENDER SERVICE**

**Q1 – Patients rating of psychological health status (anxiety, depression, emotions, feelings)**

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| POOR | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | GOOD |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Q2 – Patient’s rating of physical health status (extent of physical symptoms and bothered by illness)**

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| POOR | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | GOOD |
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**Q3 – Patient’s rating of overall quality of life (e.g. able to enjoy life, get on well with family/friends)**

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| POOR | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | GOOD |
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**Q4 – Patient’s rating of current accommodation issues (tenancy concerns, neighbour relationships, eviction issues)**

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| POOR | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | GOOD |
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