Appendix A: Basic personal information for requesting 1:1 support on the ward

**In Hospital Support**

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| --- | --- |
| \*Full Name:  Preferred name:  \*Date of Birth: | \*NHS No:  Hospital No:  \*Hospital name:  Mosaic No if known: |
| \*Permanent address: | **NHS/IDT budget holder agreement** *(for ECC reclaiming of costs)*  Name of Budget Holder:  ICB name:  Unique CCG Patient ID Code/Personal ref. (to quote on invoice):  Hours required per week:  Required Start date:  Signed:  Date: |
| \*Post code: | Position: |
| \*Telephone No:  Email contact: | Contact No:  Email contact: |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Provider** (Provider to notify SPT when normal support at home resumes):   |  |  | | --- | --- | | \***Start date:**  **End date** *(to be added by SPT once provider notify)*:  **ECC BUDGET CODE** | **Support hours provided per week:**  **Hourly rate:** | | \*Admission date to hospital: | | | \*Ward name: \*Ward Telephone No: | | | \*Ward Fax No: \*Ward staff name and contact No.: | |   \*indicates mandatory fields, if these are not filled in, the form will **NOT** be processed.  **Please return by email SPT.PackageChanges@essex.gov.uk**  To ‘’Chase’’ progress phone 033301 39975 Monday to Friday or Saturday 07774337494.  Please allow 3 hours for admin processing and communication with care provider. |

|  |  |
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| \*Staff signature: | \*Date: |

**Appendices B – Relevant sections of acute trust policies**

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