**Please use this form to make referrals for the testing of Staff, Personal Assistants or yourself if you are a Foster Carer (Staff) who are symptomatic or who live in a household where someone is symptomatic**

1. **Initial Screening**

**Please complete either a, b or c below**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. **Symptomatic Staff** | | |
| Does the individual have a high temperature? |  |  |
| Does the individual have a persistent or continuous cough? |  |  |
| Date of the onset of symptoms? |  | |

**OR**

|  |  |
| --- | --- |
| 1. **Self Isolating Staff (Non-symptomatic) but whose household contact is symptomatic and aged over 16 years of age.** | |
| Date of onset of symptoms of the household member? |  |

**Please complete all of the below in relation to the member of staff (not the member of the household):**

|  |  |
| --- | --- |
| 1. **Area of Work - what area of work does the member of staff work in?**   **(Note: must be providing frontline facing care). Please select from below:** | |
| Residential and Nursing Homes (Including Children’s Homes and Fostering) |  |
| Domiciliary Care Worker (Including through Direct Payment) |  |
| Personal Assistant (Direct Payment) |  |
| Safeguarding |  |
| Mental Health Act Assessment |  |
| 1. **Job Role - what job does the member of staff do? Please select from below:** | |
| Foster Carer |  |
| Frontline Care Staff |  |
| Personal Assistant working through direct payment |  |
| Staff working in extra care/supported living |  |
| Catering/cleaning staff in care homes |  |
| Critical Social Workers |  |
| AHMPS |  |

|  |  |
| --- | --- |
| 1. **Exception Request (Not covered by c or d above) Please provide details:** | |
|  | |
| Date of onset of symptoms? |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. **Have you had the member of staff/household members consent to make this referral?** |  |  |

**2. Employee Details**

|  |  |
| --- | --- |
| **First Name** |  |
| **Surname** |  |
| **Date of Birth** |  |
| **Postal Address** |  |
| **Contact Number** |  |
| **NI Number** |  |

**3. Household Contact Details (Must be over 16 yrs of age)**

**Only needs completing if you completed 1b above)**

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Date of Birth** |  |
| **Postal Address** |  |
| **Contact Number** |  |

**Please note all the information above is required for processing.**

**4. Organisation and Manager Details**

|  |  |
| --- | --- |
| **Organisation** |  |
| **First name** |  |
| **Surname** |  |
| **Job Title** |  |
| **Contact Number** |  |
| **Email Address** |  |

**Details of person completing this form if different to above:**

|  |  |
| --- | --- |
| **First name** |  |
| **Surname** |  |
| **Job Title** |  |
| **Contact Number** |  |
| **Email Address** |  |

**5. Prioritisation**

**If you are making multiple referrals can you please prioritise them, 1 being the highest priority:**

|  |  |
| --- | --- |
| **Priority No:** |  |

|  |  |
| --- | --- |
| **Number of hours this member of staff works?** |  |
| **How many staff do you have in total? Full Time/Part Time** |  |
| **How many staff do you have that are currently not at work?** |  |
| **What is the impact to your business if this member of staff is off work for 7/14 days? (Please see guidance)** |  |
| **Overall – how many individuals receiving care would be impacted if this member of staff was off for 7 to 14 days?** |  |
| **Are you able to replace/cover for this member of staff during their absence?** |  |
| **Any other comments:** |  |

**Key points regarding the testing arrangements:**

* It is an appointment based system
* The member of staff or their household member will be allocated an appointment slot
* Staff or the household member will be required to take ID photographic ID with them i.e. work badge, driving licence or passport
* Home testing is not available
* If the staff or household member are not well enough to attend the testing centre, this can be done when they feel better (but within 4 days of onset)

**Please not that due to the low number of tests each referral form will be prioritised against other referrals that come in.**

**Please forward this completed form to:**

[covid19-testing@conwy.gov.uk](mailto:covid19-testing@conwy.gov.uk)