



Refusal

PLEASE COMPLETE IN BLOCK CAPITALS

Home Fire Safety Check

Occupier

DOB: **Date** **Station Ground**

Name:

Address:

Town:

Postcode: Tel:

Email:

Occupancy

Property Code:

No. of Occupants:

No. under 5 years:

No. over 65 years:

Disability:

No. of smokers:

Uses a chip pan: **Yes / No**

Electric blanket: **Yes / No**

Smoke Alarms

Existing smoke alarm fitted?: **Yes/No**

Battery operated / satisfactory: **Yes/No**

Battery missing / discharged: **Yes/No**

Mains operated / satisfactory: **Yes/No**

Mains operated / defective: **Yes/No**

Service Provided

Advice on smoke alarm: **Yes / No**

	Alarms	Batts
No. of new units fitted:	<input type="text"/>	<input type="text"/>
No. of units replaced:	<input type="text"/>	<input type="text"/>

Visiting Officer

Name:

Role: Number:

Prev Office:

Ethnic Origin

White:	British	<input type="checkbox"/>	Irish	<input type="checkbox"/>
	Other White	<input type="checkbox"/>		
Mixed:	White & Black	<input type="checkbox"/>	White & Black	<input type="checkbox"/>
	Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>
	White & Asian	<input type="checkbox"/>	Other Mixed	<input type="checkbox"/>
Asian or Asian British:	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
	Bangladeshi	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
Black or Black British:	Caribbean	<input type="checkbox"/>	African	<input type="checkbox"/>
	Other Black	<input type="checkbox"/>		
Chinese or Other Ethnic Group:	Chinese	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Not Stated <input type="checkbox"/>			

Religious Belief

Declined

Section 1: Occupancy		Tick appropriate score
1	Are any occupants dependant upon assistance in the event of a fire?	8
2	Elderly occupant(s) or lone parent family.	7
3	3 or more children under 10 years, or 6 or more occupants.	7
4	None of the above.	6

Section 2: Circumstances		Tick appropriate score
1	History of fires in the home. Children currently playing with fire.	7
2	Is there anything that would affect the occupants awareness of fire, or impair their reaction to a fire situation?	8
3	Evidence of careless use of smoking materials or inappropriate cooking methods.	7
4	Inappropriate use of electrics.	5
5	Excessive fire loading.	4
6	Smokers live in household, or use of candles.	3
7	None of the above.	2
Risk Rating = Section 1 x Section 2		

Section 3: Smoke Alarms		Before	After
1	None.	0	0
2	Yes - but inadequate or inappropriately sited.	2	2
3	Yes - satisfactory.	6	6

Section 4: Fire Safety Advice		Before	After
1	No apparent fire safety awareness	0	0
2	Limited fire safety awareness	2	2
3	Good fire safety awareness	6	6
Safety Rating = Section3 + Section 4			

Final Points Rating = Risk Rating - Safety Rating	
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Prevention Equipment provided					
	Qty		Qty		Qty
Wi Safe 2 Alarm	<input type="checkbox"/>	King size bedding pack	<input type="checkbox"/>	Letter Box Plate	<input type="checkbox"/>
Pad & Strobe	<input type="checkbox"/>	Double bedding pack	<input type="checkbox"/>	Letter Box Bag	<input type="checkbox"/>
CO Alarm	<input type="checkbox"/>	Single bedding pack	<input type="checkbox"/>	Letter Box Lock	<input type="checkbox"/>
Extension Lead	<input type="checkbox"/>	Fire retardant throw	<input type="checkbox"/>	Deep Fat Fryer	<input type="checkbox"/>
Oil filled radiator	<input type="checkbox"/>	E cig pouch	<input type="checkbox"/>	Light Bulbs	<input type="checkbox"/>
RCD	<input type="checkbox"/>	Metal bin	<input type="checkbox"/>	Grip Socks	<input type="checkbox"/>

Interventions Completed					
0-7 day process	<input type="checkbox"/>	SAFE	<input type="checkbox"/>	RM1	<input type="checkbox"/>
8-21 day process	<input type="checkbox"/>	Hate Crime	<input type="checkbox"/>	Target Hardening	<input type="checkbox"/>
Non Contactable	<input type="checkbox"/>	Safe & Well	<input type="checkbox"/>	HFSC High Risk	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>				

Safe and Well

Falls Risk Assessment Tool (FRAT)

Is there a history of any fall in the previous year		YES	NO
Is the client on 4 or more medications a day		<input type="checkbox"/>	<input type="checkbox"/>
Does the client have a diagnoses of stroke, parkinsons or dementia		<input type="checkbox"/>	<input type="checkbox"/>
Does the client report problems with his/her balance		<input type="checkbox"/>	<input type="checkbox"/>
Is the client unable to rise safely from a chair of knee height		<input type="checkbox"/>	<input type="checkbox"/>
If the answer to two or more questions is YES, a referral to team is			
		YES	NO
		<input type="checkbox"/>	<input type="checkbox"/>
Falls Environment Check	YES	NO	
	<input type="checkbox"/>	<input type="checkbox"/>	

Bowel Cancer Screening (applicable to 60+)

Did you receive bowel cancer screening kit		YES	NO
Did you return kit and receive results		<input type="checkbox"/>	<input type="checkbox"/>
If no, explain benefits and ask:			
Would you like MFRS to request a kit to be sent out again		<input type="checkbox"/>	<input type="checkbox"/>

Smoking Cessation

Following discussion around the benefits of stopping smoking, would you like MFRS to provide information / referral to your local stop smoking service

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Alcohol Reduction

Following discussion around the benefits of reducing your alcohol intake, would you like MFRS to provide information / referral to your local service

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Issues identified / discussed with

INDIVIDUAL

FAMILY

CARER

Cooking	<input type="checkbox"/>	Sensory Impairment	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	Aromatics	<input type="checkbox"/>
Hoarding	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	E-Cigarette	<input type="checkbox"/>	Air flow bed	<input type="checkbox"/>
Heating	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	Oxygen	<input type="checkbox"/>
Electrics	<input type="checkbox"/>	Mobility Issues	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Carbon Monoxide	<input type="checkbox"/>

Other issues identified:

Road Safety

Does anybody (in the property) aged over 65 still drive a vehicle

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Merseyside Fire and Rescue Service (MF&RS) will process the information you supply for the purposes of reducing the risk of fire, health, safety and wellbeing

Note to Staff - As you have already explained that you need to record their details there is no further explanation required - therefore this should be answered as YES

YES NO

MF&RS will share this information securely with other agencies for the reason above. Please tick the box below if you wish to decline this. You are entitled to see your personal data held by MF&RS.

If you wish to see your personal data please contact Corporate Information Sharing Officer:
Tel No 0151 296 4416.

I decline to share this information

Onward referral required to:

Social Services	<input type="checkbox"/>	Healthy Homes	<input type="checkbox"/>	Police	<input type="checkbox"/>
Housing association	<input type="checkbox"/>	Assistive Tech	<input type="checkbox"/>	Care agency	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>	Benefits	<input type="checkbox"/>	FSN	<input type="checkbox"/>
Safeguarding	<input type="checkbox"/>	VPT	<input type="checkbox"/>	Environmental Health	<input type="checkbox"/>
British Red Cross	<input type="checkbox"/>	Age UK	<input type="checkbox"/>	Back to referrer	<input type="checkbox"/>
Local Authority	<input type="checkbox"/>	EHAT	<input type="checkbox"/>	Other	<input type="checkbox"/>

Other/Who

Useful Contacts

Merseyside Fire Control 0151 530 2627
Merseyside Police 0151 709 6010
Fire Service Direct 0151 296 4031

Memo:

Follow up Revisit 0-3 Mths 3-6 Mths 6-12 Mths Not Required