

Learning Disability and/or Autism Crisis Care Plan

Use this form to provide the basic information and details about the person you care for in the event that someone unknown to them needs to step in and provide emergency support.

This plan should give an overview. You can also attach more detailed information including their support plan, a one-page profile and any medical reports or medication needs they may have which will help if they need a care needs assessment if longer term arrangements need to be made.

If you have family and friends who might help – talk to them in advance so that they are aware that they are on the emergency contact list.

If there are no friends or family listed on this form, please contact Oxfordshire County Council’s Social and Health Care Team on

0345 050 7666
8.30 – 5.00 Monday – Thursday
8.30 – 4.00 Friday

In an emergency only outside of these hours please call 0800 833 408 (freephone)

1. What is the full name of the person who needs support?

What is their preferred name?

2. Who is their current main carer?

Name	Relationship	Address	Telephone #	Email
			M. H.	
			M. H.	

3. Who are the friends and family to be contacted in an emergency?

Name	Relationship	Address	Telephone #	Email
			M. H.	
			M. H.	
			M. H.	
			M. H.	

4. Are there any other people in your relative's life who need to be contacted?

Name	Relationship	Address	Telephone #	Email
			M. H.	
			M. H.	

5. Does your relative attend any regular activities?

	Organisation	Contact Name	Address	Telephone #	Email	Any other information?
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

6. How do they get to and from these activities?

	Organisation	Transport	Telephone #	Pick up/Drop Off time
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

7. Is there anything we need to know that would help make the journey for your relative easier?

8. Who is your relative's GP?

GP Surgery	GP Name	Address	Telephone	Do they see the GP often?	Do they have a regular health check?

9. Do they have any medical issues we should be aware of?

YES NO

Issue	Symptom	Anything we should know?

10. Do they take regular medication? (Include both prescription and non-prescription)

YES NO

Name	Frequency	How is it taken?	Anything we should know?

Where is the medication kept?

11. What other professional support and/or services does your son or daughter use? EG School, College, Day Service, Community Nurse, Occupational Therapist, Respite Service

Service or Support	Contact name	Telephone #	Email	Is this a regular service?	How often do they attend?	Anything else we should know?

12. Can your relative be left at home alone for any period of time?

Day time: YES NO

If yes, how long can they manage alone before needing someone to check on them?

Night time: YES NO

If yes, how long can they manage alone before needing someone to check on them?

13. Does your relative have any known allergies?

YES NO NOT KNOWN

Allergy	Reaction	Treatment

14. Does your relative have any special dietary requirements?

YES NO

If yes, please describe what they are

15. Is there anything about your relative that needs to be known immediately to help those who are organising their support?

For example: how to communicate with them; things that may cause them stress or distress including any triggers; any mobility issues; anything that they need to take with them including equipment or special objects?

16. What actions are to be taken in an emergency?

For example, would you prefer your relative to stay in the family home or go to stay with the person providing support?

Please say if the action will be familiar to the individual. For each choice, please make sure that you have agreement in advance from the person the plan is about (if they are able to give capacity), their family and the person providing the support.

1 st choice
2 nd choice
3 rd choice
4 th choice
5 th choice

17. Is there anything you do not want to happen?

18. Is there anything else you would like to tell us?

19. Signatures

Date Form Completed

Next review date of the emergency plan

Signature of person completing the form

Signature of person the plan is about

and/or their main carer