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**Referral Form – Request for a Carers Assessment**

**Details of Referring Agency**

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| --- | --- |
| Name of person making contact: |  |
| Agency Name: |  |
| Contact telephone number: |  |
| Email address: |  |
| Date of request: |  |

**Consent:**

**Please confirm that the client has agreed to the following:**

**YES / NO given consent for this referral to be made**

**YES / NO given consent for their personal information to be recorded by the Carers partnership**

**YES / NO Has been informed their information will not be shared more widely without their consent.**

**Please fill in ALL Boxes**.

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| **CARERS DETAILS** |
| Surname |  |
| Forenames |  |
| Address |  |
| Postcode |  |
| Date of Birth |  | Gender |  |
| Telephone No. |  | Mobile No. |  |
| Can we leave a voicemail?  | Y/N | Can we send a text message?  | Y/N |
| Email Address |  |
| Alternative contact (family/friend) |  | Alternative contact phone number |  |
| Marital Status |  | Employed |  |
| Registered with their GP as a Carer? |  | Advised Carer to register with their GP |  |
| Carer Disability/ConditionComplete if carer has a disability. health or mental health condition  |  |
| How many hours of care do they provide a week? |  |
| Does the Carer have any access needs? | Physical Access needs Y/NLanguage Y/N |
| **CARED FOR PERSONS DETAILS** |
| Surname |  |
| Forenames |  |
| Address |  |
| Postcode |  |
| Illness / Disability (please include **ALL** conditions ) |  |
| GP Surgery |   |
| Relationship to Carer |  |
| Gender |  | Ethnic Group |  |
| Date of Birth |  |
| Is there any reason that we cannot make a home visit if we need to? |  |
| **REASON FOR REFERRAL** (include any actions already taken by your agency) |
|  |
| **ARE ANY OTHER AGENCIES INVOLVED WITH THIS FAMILY?** (Including other voluntary sector orgs.) |
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**Please return this form to:** **carers@communicare.org.uk**