Please use this form to refer a carer to our services and support.

**Carer referral form**

If you are not the carer you must gain their consent before making this referral.

Please write clearly in **PRINT** (preferably black ink).

|  |
| --- |
| **Details of the carer** |
| **Title** | Mr/Mrs/Master/Miss/other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **First name** |  |
| **Last name** |  |
| **Date of birth** |  |
| **Address** |  |
| **Postcode** |  |
| **Home telephone** |  |
| **Mobile number** |  |
| **Email address** |  |
| **First language** |  |
| **Gender** |  |
| **Ethnicity** |  |
| **Does the carer have a disability or chronic health issue of their own?** | Yes |[ ]  No |[ ]
| **If yes, please detail.** |  |
| **Any communication or other needs?** | Yes |[ ]  No |[ ]
| **If yes, please detail** |  |
| **Employment/education** | School/college/university |[ ]  Home educated |[ ]
|  | Training |[ ]  In work  |[ ]
|  | Not currently in work |[ ]  Other |[ ]
|  | School/college/university/employer name (if applicable and carer consents to share) |
|  |  |

|  |
| --- |
| **Reason for referral** (please provide as much detail as possible, ensuring that any individuals mentioned have consented to their information being shared).Please highlight any urgent concerns regarding this referral and any risks/hazards we need to be aware of (e.g. in relation to lone working) and also any information about other agencies involved in providing support. |
|  |
| **Details of the person with care needs****Only complete if the person with care needs has given consent for their details to be shared with us** |
| **Full name** | **Relationship to carer** | **Date of birth** | **Age** | **Health condition/disability** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|[ ]  I confirm by ticking this box that I have consent from the person(s) named above to provide their information. |

|  |
| --- |
| **Statutory assessments and additional carer support** |
| **Has the carer had an adult statutory carer’s assessment?**(provided by Cambridgeshire County Council, Peterborough City Council or CPFT if the cared for is being supported by them). |
|[ ]  Yes |[ ]  No, don’t want one |[ ]  No, I consent to my details being shared with relevant organisation |
| **Has the cared for had an adult social care needs assessment?**(provided by Cambridgeshire County Council or Peterborough City Council). |
|[ ]  Yes |[ ]  No, don’t want one |[ ]  No, I consent to my details being shared with relevant local authority |
| **Is the carer known to Making Space? Only applicable if person with care needs is aged 18-65 and has a mental health condition.** |
|[ ]  Yes |[ ]  No, don’t want to be |[ ]  No, I consent to my details being shared with Making Space |
| **If there is a young person (aged under 18)** |
| **Are they known to Centre 33?** |
|[ ]  Yes |[ ]  No, don’t want to be |[ ]  No, I (or they if over 13) consent to their details being shared with Centre 33 |
| Name |  | Date of birth |  |
| **Has the young carer had a young carers’ needs assessment since 1 August 2020?** |
|[ ]  Yes |[ ]  No, don’t want to be |[ ]  No, I (or they if over 13) consent to my details being shared with Centre 33 |
| **Has the young adult carer had a young adult carers transitions’ assessment?** |
|[ ]  Yes |[ ]  No, don’t want to be |[ ]  No, I/they consent to details being shared with Centre 33 |
| **Referrer’s details** |
|  |[ ]  I’m the carer |[ ]  Friend/family |[ ]  Professional |
| **First name** |  |
| **Last name** |  |
| **Organisation** |  |
| **Job title** |  |
| **Contact number** |  |
| **Email address** |  |

|  |
| --- |
| **How did you hear about us?** |
|  |

|  |
| --- |
| **Confirmation** |
| Please read the below statements and confirm the by ticking box below:* I confirm that the information provided is correct.
* I confirm that I have consent from the persons mentioned on this referral to provide their information.
* I understand that the information provided will be used for the purpose of providing appropriate services and support.
* I confirm consent has been obtained for details to be shared with organisations stated in this referral.
 |
|[ ]  I confirm by ticking this box that above statements are correct and true. |

Please send referrals to:

Caring Together

L D H House

Parsons Green

St Ives

Cambridgeshire

PE27 4AA or Email: hello@caringtogether.org

**Privacy statement**

Caring Together Charity complies with the relevant data protection legislation and will use details provided in order to make contact and provide support/services. You can obtain a copy of our privacy notice by visiting caringtogether.org/privacy-policy, emailing hello@caringtogether.org or by phoning us on 01480 499090.

If you have indicated that you wish us to refer to either Cambridgeshire County Council, Peterborough City Council, CPFT, Centre 33 or Making Space for further support, we shall do this on your behalf in a secure way. You can find links to their privacy notices within our privacy policy.