|  |
| --- |
| *For office use* **Key worker:**  **ID No:**  |
|  |
| **CARER Contact Details** |
| **Name in full** |  | **Date of Birth** |  |
| **Address with postcode** |  |
| **Telephone contact** |  | **Mobile No** |  |
| **Email address** |  |
| **GP and Surgery****(if known)** |  |
|  |
| **CARER Consent** | **YES✔** | **NO✗** | **Don’t know** |
| Has the **CARER consented to contact** from us? |  |  |  |
| **Reason for referral****Any specific issues** |  |
|  |
| **CARED FOR Details** |
| **Name in full** |  | **Date of Birth** |  |
| **Address with postcode****(if different from above)** |  |
| **CARING Situation**  |
| **Relationship to CARER** |  |
| **Illness or diagnosis of CARED FOR** |  |
| **Any risk factors we should be aware of** |  |
|  | **YES✔** | **Hospital/Ward** |
| **Currently in hospital?** |  |  |
|  |
| **Referred by** |
| **Name** |  |
| **Designation** |  |
| **Organisation** |  |
| **Address** |  |
| **Telephone** |  |
| **Email** |  | **Date of submission** |  |
|  |
| **Please return this referral to** | **Email to**: admin@borderscarers.co.uk**Post to**: Borders Carers Centre, Brewerybrig, Low Buckholmside, Galashiels TD1 1RT |