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| **Referral Details Part 1** |
| **CARER DETAILS**Sections below to be completed by the Referrer. |
| **Name in full** |  |
| **Date of birth** |  |
| **Address** **with postcode** |  |
| **Landline phone number** |  |
| **Work phone number** |  |
| **Mobile phone number** |  |
| **Email address** |  |
| **Reason for referral?** |  |
| **Gender** |[ ]  Male |[ ]  Female |[ ]  Not known |
| **Ethnic Group** |[ ]  White |[ ]  Mixed/multiple ethnic |[ ]  Asian, Asian Scottish, Asian British |
|  |[ ]  African, Caribbean, Black |[ ]  Other ethnic background |[ ]  Ethnicity not known |
|  |[ ]  Carer does not want ethnicity recorded |
| **GP and Surgery**  |  |
| **Does carer have any communication needs**Communication support needed |[ ]  No |[ ]  Yes(Record support needed below) |
|  |  |
| **Has carer given their consent for referral?** | **Yes**:  | **No**:  |
|  | *Under data protection regulations, we cannot accept a referral without carer consent.* |

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| **CARED FOR DETAILS**Sections below to be completed by the Referrer. |
| **Name in full** |  |
| **Date of birth** |  |
| **Address** **with postcode**(if different from carer) |  |
| **Gender** |[ ]  Male |[ ]  Female |[ ]  Not known |
| **Ethnic Group** |[ ]  White |[ ]  Mixed/multiple ethnic |[ ]  Asian, Asian Scottish, Asian British |
|  |[ ]  African, Caribbean, Black |[ ]  Other ethnic background |[ ]  Ethnicity not known |
|  |[ ]  Cared for does not want ethnicity recorded |
| **GP and Surgery**  |  |
| **Relationship to the Carer** |  |
| **Is cared for in Hospital?** | **NO** | **YES** | **Don’t know** | **Which hospital & ward?** |
| **Tick appropriate box** |  |  |  |  |
| **Is cared for Palliative?** | **NO** | **YES** | **Don’t know** |
| **Tick appropriate box** |  |  |  |
| **Any Risks we should be aware of, should a Face to Face visit be required** |  |

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| **Client group**(tick at least one group but more where appropriate)**Cared for** - Illnesses and/or diagnosis |[ ]  Dementia |[ ]  Mental Health |[ ]  Learning Disability |
|  |[ ]  Autistic Spectrum Disorder |[ ]  Physical/sensory disability |[ ]  Neurological conditions (excluding dementia) |
|  |[ ]  Drug problem |[ ]  Alcohol problem |[ ]  Elderly frail |
|  |[ ]  Cancer |[ ]  Palliative Care |[ ]  Not known |
|  |[ ]  Other condition(s) (complete box below) |  |

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| **First Contact Details Part 2**Sections below can be completed by the Referrer, should they have any of this information. BCC will contact Carer to identify any missing information.  |
| **THE CARING ROLE** |
| **How long has the carer provided care** |[ ]  Less than 1 year |[ ]  1 year but less than 5 years |[ ]  5 years but less than 10 years |
|  |[ ]  10 years but less than 20 years |[ ]  20+ years |[ ]  Not known |
| **Average number of hours care provided a week** |[ ]  Up to 4 hours |[ ]  5-19 hours |[ ]  20-34 hours |
|  |[ ]  35-49 hours |[ ]  50+ hours |[ ]  Not known |
| **Type of care given by carer** (all that apply) **Details** |
| Financial Support  |[ ]   |
| Help with medication |[ ]   |
| Help with personal care |[ ]   |
| Help with shopping, cleaning, domestic tasks |[ ]   |
| Help with transport |[ ]   |
| Supervision/emotional support |[ ]   |
| Other (provide details) |[ ]   |
| Not known |[ ]   |
| **Areas of carer’s life affected by caring** (all that apply) |[ ]  Emotional well-being |[ ]  Employment |[ ]  (Not) Feeling valued  |[ ]  Finance |
|  |[ ]  Future plans |[ ]  Health |[ ]  Life Balance |[ ]  Living environment |
|  |[ ]  Other/Not known |  |
| **Is carer ABLE to provide care** |[ ]  Yes |[ ]  No |[ ]  Not known |
| **Is carer WILLING to provide care** |[ ]  Yes |[ ]  No |[ ]  Not known |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Is there a Power of Attorney in place** |  | Yes |  | No |  | Not known |
| **Does cared for have capacity Yes/No** |  | Yes |  | No |

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| **Referrer Details** Sections below to be completed by the Referrer. |
| **Name** |  |
| **Job title** |  |
| **Organisation** |  |
| **Address** |  |
| **Telephone** |  |
| **Email** |  |
| **Date of submission** |  |

**Please return your referral by email or post using the contact details below.**

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| **Other information discussed with Carer**Sections below to be completed by BCC. |
|  |
| **Carers Occupation/s**  |  |[ ]  Military service |
| **Carers Health conditions** |  |
| **Carers Support Plan offer** |
|[ ]  CSP agreed by carer |[ ]  CSP to discuss with CLW at next call |[ ]  CSP not appropriate |[ ]  CSP declined by carer | [ ]  | Not known |
| **Date completed** |  | **CLW Name** |   |