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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 | | |

|  |  |
| --- | --- |
| **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** | |  | | | | |