**A logo for carers partner

Description automatically generatedReferral Form – Request for a Carers Assessment**

**Details of Referring Agency**

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

**Consent:**

Please confirm that the client has agreed to the following:

YES / NO given consent for this referral to be made to the Carers Partnership.

**Please fill in ALL Boxes**.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CARERS DETAILS** | | | | | |
| Surname |  | | | | |
| Forenames |  | | | | |
| Address |  | | | | |
| Postcode |  | | | | |
| Date of Birth |  | | Gender | | \* Male / Female / Other / Prefer not to say |
| Contact Phone No(s) |  | | Ethnic Group | | \* Prefer not to say |
| 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 | | Y/N |
| Registered with their GP as a Carer? | Y/N | | Advised Carer to register with their GP | | Y/N |
| GP Surgery |  | | | | |
| Carer Disability/Condition  Complete if carer has a disability. health or mental health condition |  | | | | |
| How many hours of care do they provide a week? | \*1-7 / 8-14 / 15-21 / 22-28 / 29-35 / 36-42 / 43-49 / 50+ | | | | |
| Does the Carer have any access needs? | Physical Access needs Y/N Language Y/N | | | | |
| **CARED FOR PERSONS DETAILS** | | | | | |
| Surname |  | | | | |
| Forenames |  | | | | |
| Address |  | | | | |
| Postcode |  | | | | |
| Illness / Disability (please include **ALL** conditions ) |  | | | | |
| GP Surgery |  | | | | |
| Relationship to Carer |  | | | | |
| Gender | **\*** Male / Female/ Other / Prefer not to say | Ethnic Group | | **\***Prefer not to say | |
| Date of Birth |  | | | | |
| Is there any reason that we cannot make a home visit if we need to? |  | | | | |
| **PRIMARY SUPPORT NEEDS OF THE CARED FOR PERSON** | | | | | |
|  | | | | | |
| **REASON FOR REFERRAL** (include any actions already taken by your agency) | | | | | |
|  | | | | | |
| **ARE ANY OTHER AGENCIES INVOLVED WITH THIS FAMILY?** (Including other voluntary sector orgs.) | | | | | |
|  | | | | | |

**Please return this form to the appropriate agency as per below:**

**Caring for a child or adult with a Learning Disability and or Autism in Reading?**

**Reading Mencap**, Information & Advice and Carers Assessments **Tel:**0118 926 3600: **Email:**[carers@readingmencap.org.uk](mailto:carers@readingmencap.org.uk) **Website:** www.readingmencap.org.uk

**Caring for someone 50+ years in Reading?**

**Age UK Reading,** Information & Advice and Carers Assessments **Tel:**07716 418 941: **Email:**[carers@ageukreading.org.uk](mailto:carers@ageukreading.org.uk) **Website:**[www.ageuk.org.uk/reading/](http://www.ageuk.org.uk/reading/)

**For all other carers in Reading:**

**CommuniCare**: Information & Advice and Carers Assessments **Tel:**0118 926 3941: **Email:**[office@communicare.org.uk](mailto:office@communicare.org.uk) **Website:**[www.communicare.org.uk](http://www.communicare.org.uk/)