**Staffordshire County Council Adult Carers Referral Form**

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| **Referrer’s Details** | | | |
| Referrers Name: |  | Relationship/ Agency: |  |
| Date of Referral: |  | District: |  |
| Email Address: |  | Tel No |  |
|  |  | Mobile No: |  |
| Consent: **(Please note without consent we will only accept the referral from the date we receive data consent).** | “Data Protection Act 1998 – We need to collect the information in this Adult Carer referral form so that we can understand what help is needed. We will need to share this information with Staffordshire Together for Carers who are the commissioned service to support Carers living in Staffordshire whose staff have a current Disclosure and Baring Service (DBS) check. They will treat your information as confidential and will not share it with any other organisation unless they are required by law to share it or unless the Carer will come to some harm if they do not share it. In any case they will only share the minimum information they need to share. There may be occasions when they do have to talk to someone without your permission. This will only happen in certain circumstances and when staff feels it is absolutely necessary. These circumstances include when there is a risk of serious harm, when there are Adult Safeguarding concerns or in extreme circumstances when they are ordered by the courts. Whenever possible they discuss this with you and try to involve and support you through this process.”  **Please place an X to confirm you have obtained consent from the Carer regarding making this referral and have explained the Data Protection statement above:**  **Yes No** | | |

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| **Carer’s Details – one form per Carer** | | | |
| Name of Carer |  | DOB: |  |
| Known as: |  |
| Gender: |  | Ethnicity: |  |
| First Language: |  | Immigration Status: |  |
|  | | | |
| HomeAddress: |  | Tel No: |  |
| Mobile No: |  |
| Email: |  |
| GP Name: |  | GP Address: |  |

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| **Any Additional Needs/support to be aware of for the Carer?** |  |

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| **Cared for Details: (People who the Carer looks after/supports)** | | | | | |
| Name: | Relationship to Carer: | Date of Birth: | Gender: | Same address as Carer? | Illness/Disability/  Condition: |
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| **Other Household Family Members:** | | | |
| Name: | Relationship to Carer: | Date of Birth: | Are they also a Carer? |
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| **Caring Role Breakdown** | | | | | | |
| Please explain the caring role of the Carer? | | | | | | |
| Caring Role:  Please tick all applicable | Personal Care | Emotional /Mental Health Support | Household Tasks | Sibling Care | Medication | Financial |
|  |  |  |  |  |  |

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| **Any Known Risks – environmental, safeguarding concerns, family dynamics, worries or concerns** | | |
| Details: | | |
|  | **Carer** | **Cared for** |
| Any other Key Professionals involved: |  |  |

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| **Reason for Referral:** |
| Please give your views on the desired outcome of this referral and where possible include the views of the Carer where applicable: |
| **Any other information you feel may support this referral?** |
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| **What Next?** |
| Email this referral to: firstcontactcarers@staffordshire.gov.uk  If you need further support contact: firstcontactcarers@staffordshire.gov.uk or 0300 111 8010 |