**CARER SERVICES REFERAL FORM**

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| **Carer being referred information** |
| **Carers First Name:** | **Carers Surname:** |
| **DOB:** | **Age** | **Gender** Male/Female |
| **Address:****Post Code:** | **Dependents:**(Children and ages) |
| **Contact details****Mobile Number:****Home Number:** |
| **Nationality:****Ethnicity:** | **Immigration Status:** UK National / EUNational /No Recourse to Public Funds/Other |
| **Reason for Referral** (Include details of person, they are caring for -Sickle Cell, elderly, frail, sick or disabled family member) |
| **SUPPORT NEEDS** (Indicate if support need is high, medium or low) |
| **Area of Support** | **** | **Area of Support** | **** |
| Access to carers assessment |  | Hardship Support |  |
| Social contacts and meeting others |  | Finances/Debt and Welfare Benefits |  |
| Peer support |  | Healthy Lifestyles; nutrition |  |
| Volunteering |  | Parenting support  |  |
| One-to-one support  |  | Signpost/Refer to other services |  |
| Advice, guidance and information |  |  |  |
| **For Health and Social Care statutory service.** Please give any other information including risk assessment/care plan: Including other health conditions, disabilities, risk of harm to self or others, mental health. |
| **GP Details:****Address:****Telephone:** |
| **CONSENT** |
| **I hereby give my informed consent for referring agency to provide information about me and I confirm that I wish to receive support as detailed in this referral.**  **I understand any information will be held electronically and manually and will be shared with relevant person(s) to safeguard your welfare, interests and promote your well-being, support and care needs.** **We agree to the information being held and shared as described. If you are unable to consent than we are unable to accept your referral for support.**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Referral Agency details:** | Name:Agency:Address:Email:Phone:Date: |
| **Acknowledgement of Referral:** | By: Date: |

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| **Send this form to:** | **Post-OSCAR Birmingham, 22 Regent Place, Birmingham, B1 3NJ or** **email** **admin@oscarbirmingham.org.uk** |
| **Further Information:** | Phone: 0121 212 9209 www.oscarbirmingham.org.uk |