**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 / EU  National /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**](mailto:admin@oscarbirmingham.org.uk) |
| **Further Information:** | Phone: 0121 212 9209  www.oscarbirmingham.org.uk |