**Telford and Wrekin Young Carers Service**

**Telford and Wrekin CVS**

**The Glebe Centre**

**Glebe Street**

**Wellington**

**Telford**

**TF1 1JP**

**01952 240209**

[**info@telfordandwrekinyoungcarers.org.uk**](mailto:info@telfordandwrekinyoungcarers.org.uk)

**www.telfordcarers.org.uk**

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**PC VERSION – WITH FILLABLE FIELDS**

Telford and Wrekin Young Carers Service

Referral and Initial Information Record

**CHILD/YOUNG PERSONS DETAILS**

|  |  |
| --- | --- |
| Family Name: |  |
| Forename/s: |  |
| Address: |  |
|  |  |
|  |  |
| Postcode: |  |
| Tel No: |  |
| Mobile: |  |
| Date of Birth: |  |
| Age: |  |
| Current Address:  (if different from above) |  |
|  |  |
|  |  |
| School: |  |
| School Type: |  |
| If none of the above please specify: |  |
| Does child have SEN?: | Yes  No |
| If Yes, is there a Statement: | Yes  No |
| School Attendance (if known): |  |
| GP Name: |  |
| GP Practice: |  |
| GP Tel No: |  |

**REFERRAL DETAILS**

|  |  |
| --- | --- |
| Referred by: |  |
| Referral Date: |  |
| Does young person know about referral?: | Yes  No |
| Does parent known about referral?: | Yes  No |
| Agency/relationship to the child/young person?: |  |
| Where did you hear about the Young Carers Service?: |  |
| Method of enquiry: |  |

**PERSON WITH PARENTAL RESPONSIBILITY**

|  |  |
| --- | --- |
| Name: |  |
| Relationship to young carer: |  |

**SIGNIFICANT OTHER FAMILY AND HOUSEHOLD MEMBERS**

|  |  |  |  |
| --- | --- | --- | --- |
| Family name | Forename/s | DOB | Relationship to young carer |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**ETHNICITY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| White British |  | Pakistani |  | Other Asian background |  |
| Traveller of Irish Heritage |  | Bangladeshi |  | White and Black Caribbean |  |
| Gypsy |  | Chinese |  | White and Black African |  |
| Other White background |  | Caribbean |  | White and Asian |  |
| Black or Black British |  | African |  | Other Mixed background |  |
| Indian |  | Other Black background |  | Other ethnic group |  |
| Not given |  | If other please specify: | | | |
| Child’s first language: |  | | | | |
| Parent’s first language: |  | | | | |
| Is an interpreter required?: | Yes  No | | | | |
| Has this been arranged?: | Yes  No | | | | |

**INFORMATION ON STATUTORY STATUS**

|  |  |
| --- | --- |
| Young person/others in family on Disability Register?: | Yes  No |
| If yes, name of person: |  |
| Date registered: |  |
| Young person/other child on Protection Register?: | Yes  No |
| If yes, name of person: |  |
| Date registered: |  |
| Category: |  |
| Young person/family member looked after by local authority?: | Yes  No |
| If yes, name of person: |  |
| Date started: |  |

**DETAILS OF PERSON/PEOPLE YOUNG PERSON IS CARING FOR**

|  |  |
| --- | --- |
| Name of person/s young carer is caring for: |  |
| Relationship to young carer: |  |
| Address (if different from young carer): |  |
|  |  |
|  |  |
| Illness/disability/diagnosis of person being cared for |  |
| Has the cared for had a Community Care Plan?: | Yes  No  Don’t know |
| Are there any additional services provided?:  (eg Home Help, District Nurse) |  |
|  |  |

**DETAILS OF OTHER AGENCIES/PROFESSIONALS INVOLVED WITH THE FAMILY**

|  |  |  |  |
| --- | --- | --- | --- |
| Agency |  | Name | Tel No |
| GP |  |  |  |
| School/Learning Mentor |  |  |  |
| Youth Offending Team (YOT) |  |  |  |
| Community Mental Health |  |  |  |
| School Nurse |  |  |  |
| Health Visitor |  |  |  |
| Educational Welfare Officer (EWO) |  |  |  |
| Police |  |  |  |
| Dentist |  |  |  |
| Community paediatrician |  |  |  |
| Social worker/Community Care Assessor |  |  |  |
| Other |  |  |  |

**DETAILED INFORMATION**

|  |
| --- |
| What caring tasks does the young person carry out? |

|  |
| --- |
| How does the caring role impact on the young person? |

|  |
| --- |
| Reason for referral/current situation? |

|  |
| --- |
| Are there any issues/needs relating to home visits? |

**PERSON COMPLETING THE REFERRAL**

|  |  |
| --- | --- |
| Self Referral: | Yes  No |
| Agency: |  |
| Designation: |  |
| Address: |  |
| Contact Tel No: |  |
| Mobile: |  |
| email: |  |
| **Signature:** |  |
| Date: |  |

|  |
| --- |
| Any additional notes about referral: |

**PLEASE ADHERE TO GDPR AND PASSWORD THIS FORM FOR COMPLETE SECURITY.**

**PLEASE RETURN ONLY BY EMAIL AS OF 1ST April 2020 as no postal system in place currently.**

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