****

**Telford & Wrekin Young Carers Service**

**Suite 12 and 15**

**Hazledine House**

 **Telford**

**TF3 4JL**

**01952 240209**

**info.youngcarers@telfordcarers.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 *(PC fillable and multiple-choice format)*

**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: |  |

1.

 **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) |       |
|  |       |

2.

**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?      |

3.

|  |
| --- |
| 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 RETURN THIS FORM TO:**

**Telford and Wrekin Young Carers Service**

**Suite 12 and 15**

**Hazledine House**

**Telford**

**Shropshire**

**TF3 4JL**

**or email to:**

**info.youngcarers@telfordcarers.org.uk**

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