**All sections of this form MUST be completed in order for the carer to be registered with Salford Carers Service. Thank you.**

**Please return this form to:**

**Salford Carers Centre, Langworthy Cornerstone, 451 Liverpool Street, Salford, M6 5QQ or email:** **salford.carers@gaddum.org.uk** **or contact 0161 212 5451**

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| **Carer Information**  |
| Title: |  | Home address and Post Code:  |  |
| Forename: |  |
| Surname: |  |
| Date of Birth: |  |
| Home Tel. No.: |  |
| Mobile No.: |  |
| Can answerphone messages be left? | Home: | Y/N | Mob: | Y/N |
| Can we text? |  🞏 Yes 🞏 No |
| Email: |  |
| Would you like to receive our newsletter? |  🞏 Yes 🞏 No |
| Preferred language: |  |
| Access needs: |  |
| Other requirements: |  |
| Employment status: | 🞏 Full time 🞏 Part time 🞏 Student 🞏 Unemployed 🞏 Retired |
| Has the carer had a carer’s assessment? |  |
| GP name and practice address: |  |
| Can we share information with your GP? | 🞏 Yes 🞏 No |

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| **Demographic Information**This information is used for monitoring purposes and to signpost service users to relevant services. Any information given should be determined by the person being referred, given voluntarily, and will be stored confidentially in line with data protection laws. (Our funders require this information). |
| Gender: |  | Faith or religion: |  |
| Ethnicity: |  | Sexual orientation: |  |

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| **Safeguarding** |
| Any known risks? |  |

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| **Cared for Information** |
| D.O.B of the cared for? |  |
| Relationship to carer? |  |
| What is the condition of the cared for? |
| 🞏 Mental Health  |  | 🞏Learning Disability |  | 🞏Sensory |  | 🞏Autism | 🞏Drug/alcohol |
| 🞏Cancer |  | 🞏Alzheimer/dementia |  | 🞏Heart |  | 🞏Stroke | 🞏Elderly/frail |
| 🞏Physical illness/disability | 🞏 Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Has the cared for ever had an assessment? |  |
| Reason for Referral: |

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| **Referrer Information** |
| Referred by: |  |
| Organisation: |  |
| Job Title: |  |
| Contact Number: |  |
| Signature: |  | Date of referral: |  |

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| Has the person being referred consented to this information being shared? | 🞏 Yes 🞏 No |

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| **FOR OFFICE USE ONLY** |
| **Allocated Social Worker:** |  |
| **Date of Contact:** |  |