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|  | | | **SALFORD CARERS SERVICE**  **REFERRAL FORM – HOSPITAL PROJECT** | | | | | | | | | | | | | |  |
| **DETAILS OF CARER BEING REFERRED** | | | | | | | | | | | | | | | | | |
| Name and Address of Carer: | | | | | | | | | Email Address: | | | |  | | | | |
| Are there any Safeguarding concerns? | | | |  | | | | |
| Home Tel No: | | | |  | | | | | | Carer’s DOB: | | |  | | | | |
| Mobile No: | | | |  | | | | | | Can messages be left? | | | Home  YES 🞏 NO 🞏 | | Mobile  YES 🞏 NO 🞏 | | |
| Carer’s P Number | | | |  | | | | | | Date of Referral: | | |  | | | | |
| Please indicate if the carer has any particular communication/access needs? | | | | | | | | |  | | | | | | | | |
| Carer’s Employment status: | | | | | | | | | F/T 🞏 P/T🞏 Student 🞏 Unemployed 🞏 Retired 🞏 | | | | | | | | |
| **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.** | | | | | | | | | | | | | | | | | |
| Carer’s Ethnicity: | | | |  | | | | | | Faith or Religion: | | |  | | | | |
| Gender: | | | |  | | | | | | Sexual Orientation: | | |  | | | | |
| Has the carer ever had a carer’s assessment? What year? | | | | | | | | | | | | |  | | | | |
| Has the person referred consented to this information being shared? | | | | | | | | | | | | | YES 🞏 NO 🞏 | | | | |
| How long have they been a carer? | | | | | | | | | | | | |  | | | | |
| **DETAILS OF THE CARED FOR:** | | | | | | | | | | | | | | | | | |
| Name and Address of Cared for | | | |  | | | | | | | | | | | | | |
| Cared For P No: | | | |  | | | | | | Cared for DOB: | | |  | | | | |
| Relationship to Carer: | | | |  | | | | | | Hospital Ward: | | |  | | | | |
| 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Reason for referral: | | | | |  | | | | | | | | | | | | |
| Referrer Name and Phone No. | | | | |  | | | | | | | | | | | | |

Please password protect this document and email back to [ect@gaddum.org.uk](mailto:ect@gaddum.org.uk) or call 0161 212 5451