**Carers Support Pembrokeshire**

**Referral Form**

**Please tick the support that you require:**

**Carer Information – (Carers Information Pack, Carers Newsletters, factsheets, general support)**

**Carer Support - (1 to 1 tailored support to explore options for practical and emotional support with caring role)**

**Money Matters Service - (Carers grants, discounts & concessions, advice on maximisation of income/budgeting)**

**Time Together – (offering short breaks, trips, activities, socialisation & peer support)**

**Carer’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Title: Name: | | Date of Birth:  Gender: | |
| Address:  Town: Post Code: | | | |
| Telephone: | | Mobile: | |
| Email address:  **Please note that if you provide an email address you will receive information inc. Newsletters, etc. by email** | | | |
| GP Surgery: Click or tap here to enter text. | | | |
| How long have you been providing care? (current caring role): Click or tap here to enter text. | | | |
| Do you care for more than one person? Yes  No  If yes please state how many people you provide care for: Click or tap here to enter text. | | | |
| Who do you care for and what is their main illness/disability/condition? (Please tick all applicable)   * A parent Their main illness/disability/condition: Click or tap here to enter text. * A spouse / partner Their main illness/disability/condition: Click or tap here to enter text. * A child – including adult children Their main illness/disability/condition: Click or tap here to enter text. * A sibling Their main illness/disability/condition: Click or tap here to enter text. * Extended family member Their main illness/disability/condition: Click or tap here to enter text. * Friend / neighbour  Their main illness/disability/condition: Click or tap here to enter text.   Who is the main person you care for?: Click or tap here to enter text. | | | |
| **How would you say you are currently coping with your caring role?**  ***(please tick)*** | | | |
| Coping well | Just managing | | Really struggling |
| **If you (the carer) feel that you are at crisis point or the person you care for is in crisis please be advised to contact Delta Wellbeing directly on: 0300 3332222** | | | |
| **Do you (the carer) have a disability or any illness or health issues?**  If yes, please give details: Click or tap here to enter text.  **Are you employed (either part-time or full-time)?** Yes  No | | | |

**Referral Form**

**Support needs:**

|  |  |
| --- | --- |
| **What kind of support would you like to receive? *(please tick all that apply)*** | |
| Carers Information (e.g. general carer enquiries/where to get help, etc.) |  |
| Carers Needs Assessments |  |
| Carers Emergency Card / Contingency & Emergency Planning |  |
| Condition Specific Information |  |
| Support for Mental Health and Emotional Wellbeing |  |
| Support for Physical Health and Wellbeing |  |
| Access to Peer Support Groups |  |
| Access to free Legal Advice session (issues relating to caring; e.g. LPA, etc.) |  |
| Respite / leisure breaks |  |
| Other (please specify): Click or tap here to enter text. |  |

**Other:**

|  |  |  |
| --- | --- | --- |
| **What language would you prefer to communicate in?** | | |
| English | Welsh | Other (please specify): |
| **Would you like to receive / continue receiving our Carers Newsletters?** | | |
| Yes  No | | |

**For Agencies Only:**

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| **Has the Carer provided consent for this referral and sharing their information with Carers Trust Crossroads West Wales?**  YES  NO |

**Referrer details:**

|  |  |
| --- | --- |
| Name: | Organisation & Job title: |
| Address:  Post Code: | |
| Telephone: | Mobile: |
| Signed: | Date: |

**Self-Referrals:**

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| How did you hear about us? Click or tap here to enter text. |

**Signed** (Carer): Click or tap here to enter text. **Date**: Click or tap to enter a date.

**Telephone Referral Yes  No**

|  |
| --- |
| **Risk Assessment**  **To be completed for all new one-to-one appointments**   1. Do you have a disability or any health problems that we need to be aware of?   YES  NO  If yes, please give details: Click or tap here to enter text.   1. Are there any risks that we need to be aware of when coming to your home?   For example, from pets, neighbours, etc.?  YES  NO  If yes, please give details: Click or tap here to enter text.   1. Will there be anyone else present or visiting the property during our appointment?   YES  NO  If yes, please give details: Click or tap here to enter text.   1. Do you or anyone else living with you have any mental health or drug or alcohol problems?   YES  NO  If yes, please give details: Click or tap here to enter text.   1. Have you or any family members previously been subjected to any aggressive or abusive behaviour from anyone in your home?   YES  NO  If yes, please give details: Click or tap here to enter text.   1. Are you or the person you care for receiving support from any other agency? If so, are you happy for us to share information with them? (to avoid duplication of work and give you the best service).   YES  NO  If yes, please give details: Click or tap here to enter text.   1. Have you or anyone that you have been in contact with been diagnosed with Coronavirus, is showing symptoms of the Coronavirus and / or has been advised to self-isolate?   YES  NO  If yes, please give details: Click or tap here to enter text. |

Please email completed forms to: [carerssupportpembs@ctcww.org.uk](mailto:carerssupportpembs@ctcww.org.uk) or Telephone: **0300** **0200 002** for our postal address.

*This information will be stored and handled securely in accordance with the Data Protection Act 1998*