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***Young Carers Service Referral Form:***

***Please read the guidance notes first***

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| **Referrer’s Details (Person sending in the form)** | | | | |
| Name |  | Title or Role |  | |
| Agency or school |  | | | |
| Phone Number |  | Email | | |
| In my absence, speak to: |  | Has the young person consented to the referral? | |  |
| Please give details if the young person or anyone else in the family has previously received support from York Carers Centre? ***If you are making a re-referral please tell us about the reasons, e.g. change to caring need / responsibility, or change of impact.*** | | | |  |

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| **□ Young Carer Information □** | | | | | |
| Name | Age | Date of Birth | | | Gender |
|  |  |  | | |  |
| Address \* | | | | | |
| Relationship to cared for person | Son | | Daughter | Sibling | Other (please specify): |
| Estimated number of hours spent caring per week | 1 - 19 | | 20 - 49 | 50+ |  |
| Name and address of GP: | | | | | |

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| Name of School/ college or home educated | |  |
| Are school / college aware of caring situation at home? | | **Yes  No** |
| Does the young person have Special Educational Needs, health issues or other needs of their own?  If Yes please give details | | **Yes  No** |
| Preferred Language: | English | Other (please give details – name/dialect/sign etc)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Parent / Guardian Information** | |
| **Parent/Guardian 1**  Name:  Address if different to young person:  Mobile:  Email:  Ethnicity: | **Parent/Guardian 2**  Name:  Address if different to young person:  Mobile:  Email:  Ethnicity: |

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| **Information about the Cared-For Person** | |
| Name of person(s) being cared for: | Relationship to young carer: |
| Date of Birth(s): | Address if different to young carer |
| Illness/disability/ condition of person(s) being cared for:  What are the impacts and needs resulting from the illness/disability/condition?  (e.g. physical impacts, emotional impacts, parenting capacity etc) | |
| Are there any specific requirements from the family arising from sensory impairment/ language difficulties etc? (eg. Is an interpreter required?) Yes ☐ No ☐  If yes, please give details: | |
| At the time of the referral where is the **cared for person** (Please tick):  At home  In hospital  Somewhere else (please specify) | |

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| **Family Details**  Please include people who live at home with the young person or elsewhere | |
| Name of adults and relationships to young person: |  |
| Names and dates of birth of siblings: |  |

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| **Reason for Referral and impact of caring**  Please describe in detail all practical and/or emotional caring responsibilities and the impact this has on the young person. This may include impact on education, physical health, emotional and mental health, behaviour, family and social relationships, |
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| **Caring Responsibilities Undertaken by the Child or Young Person** | |
| **PRACTICAL** | **EMOTIONAL** |
| Washing the dishes | Listening to CFP ( Cared-for person**)** |
| Laundry | Worry about CF |
| Cooking | Don’t want to leave CFP |
| Cleaning | Understand CFP’s mood |
| Helping with siblings | Prompt CFP |
| Shopping | Help CFP keep / attend appointments |
| **PERSONAL** |  |
| Helping cared-for person **(CFP)** dress | Any other information about the young person’s responsibilities: |
| Helping CFP bath/shower |
| Helping CFP toilet |
| Helping CFP in/out of bed |
| Give medication |

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| **From your perspective as referrer,**  **How do you feel York Carers Centre can best support this child/young person?** |
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| **Information on Other Agencies Involved**  Please give names and contact details and brief description of their work with the family | | | | | | | | | | |
| Work being undertaken by the referring agency | | |  | | | | | | | |
| Other agencies involved with child, young person or family  (e.g. social worker, CPN, CAMHS, Adult Social Care, CAMHS, IDAS, the Island etc.) | | |  | | | | | | | |
|  | | |  | | | | Name and contact details of Lead Professional | | | |
| Is the child / young person the subject of a Child Protection plan? | | | Yes  No | | | |  | | | |
| Is the child / young person the subject of a Child in Need plan? | | | Yes  No | | | |  | | | |
| Is there an Early Help plan in place for the child / young person or family? | | | Yes  No | | | |  | | | |
| **Risk Indicators**  This information is required to allow staff to prepare for the assessment fully.  Is there any history or evidence of the following? | | | | | | | | | |
|  | Yes | No | | Don’t know |  | Yes | | No | Don’t know |
| Aggression |  |  | |  | Self Harm |  | |  |  |
| Domestic Abuse |  |  | |  | Sex Offences |  | |  |  |
| Mental health conditions |  |  | |  | Court orders |  | |  |  |
| Please give further details:- | | | | | | | | | |
| **Are you aware of any risks associated with home visits? (e.g access to property, environment, animals etc):-** | | | | | | | | | |

**Signatures:**

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| **I have read or seen the Young Carers leaflet and I am happy to be referred to the Young Carers Service.** | |
| Signature of child or young person |  |
| **I am happy for a referral to be made for my child. I understand and agree that my child will be placed on a waiting list before a member of the team will make contact.** | |
| Signature of parent or carer |  |
| I have explained the nature of the service and completed the referral criteria checklist. | |
| Signature of referrer |  |