

***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 |  |