



Young & Sibling Carers Referral Form

Carers in Bedfordshire may be asked to share your personal information with the people who fund our project. These are Bedford Borough Council, Central Bedfordshire Council and N.H.S Bedfordshire. Please specify if you agree with this. It may be that if you do not agree, that this referral cannot be processed.

I agree to this

I do not agree to this.

All questions with * must be completed.

*Referral Date:	*Referrer's Name:
*Organisation:	Email Address:
*Address:	*Telephone Number: Mobile Number:

Person being referred

*Name of Carer:	*DOB:	Gender:	
Address (including post code):	Religion:	Ethnicity:	
	*Home Tel:		
	*Parent name & mobile:		
*GP Surgery:	GP Name:		
*School / College name & address:	Are school aware that the young person is a carer?	YES	NO
	If no, do you consent to us sharing this information?	YES	NO
School Contact:			

Cared For:

*Name:	*DOB:	*Relationship to Carer:
*Address of person being cared for:		*Diagnosis:

*Are there any other carers in the family?	YES	NO
---------------------------------------------------	-----	----

If yes, please give details

***Reasons for referral and outcomes you would like from this referral:**

***Has an Early Help Assessment been completed?**

YES

NO

***Is the young person under a Social Care plan (Child Protection, Child in Need) or Team Around the Family Plan?**

YES

NO

If yes, please attach plan or give Lead Professional name and number.

Please use this space to provide any further information as necessary:

**PLEASE ENSURE ATTACHED HOME VISIT RISK ASSESSMENT IS COMPLETED BEFORE SUBMITTING THIS REFERRAL.
Failure to do so may result in the referral not being processed.**

***Do you have verbal / written consent for this referral from the parent? YES / NO**

Parent/Guardian's Signature

Date.....

Referrer's signature.....

Date.....

PLEASE RETURN TO:

Carers in Bedfordshire

Suite K, Sandland Court
Pilgrim Centre, Brickhill Drive
Bedford
Bedfordshire
MK41 7PZ

Telephone: 0300 111 1919
Fax: 01234 341766
Email: young.team@carersinbeds.org.uk
Web: www.carersinbeds.org.uk

*Home Visiting Risk Assessment

Family Name	Address	Contact Details	
Date completed:	By Whom:		
		Yes	No
Are there any known physical aggression/challenging behavior or domestic abuse?			
Have any risk been identified by any other agency?			
If so, what are they?			
Any substance or alcohol misuse?			
Are there any comprehension or language vulnerabilities?			
Are the entrances /exits to the property easily accessible?			
Are there any dangers/hazards associated with the property?			
Are you aware of any intimidating /threatening clients, relatives or friends living at or likely to visit the property?			
Are there pets in the household, are they threatening?			
If yes, what are they?			
Are any members of the household pregnant?			
Do any members of the household smoke?			
Do any members of the household have any other health conditions?			
If so, what are they?			
Is there any parking			
Areas of concern			