Carers Trust Crossroads Sir Gar Services - Carers Referral Form

Please tick Services required:
Information Service ☐ **Outreach Service** ☐ **Hospital Service** ☐

Carer's details:

Name:		Date of Birth:
Address: Post Code:		
	Mobile:	
Email address:		
GP Surgery:		
How long has the carer been providing care? (current caring role)		
Details of the 'cared for' illness/disability/condition: GP Surgery:		
How would you say the carer is currently coping with their caring role? *(please tick)*		
Coping well	Just managing	Really struggling
If the carer feels they are at crisis point please advise them to contact Delta Wellbeing directly on 0330 333 2222		
Does the carer have a disability or any illness or health issues? If yes please give details:		

Support needs

What kind of support would the carer like to receive? *(please tick all that apply)*	
Carers Information (e.g. legal rights, where to get help)	
Other Information (condition specific)	
Signposting/Referral to Other Services	

Financial advice (e.g. benefits advice, grants)	
Support for physical wellbeing	
Support for mental/emotional wellbeing	
Access to peer support groups	
Access to employment/voluntary work	
Training (e.g. infection control, stress management)	
Demonstrations (e.g. safe moving & handling)	
Respite/leisure breaks	
Carers Newsletter	
Other (please specify) …	

Other

What language does the carer prefer to communicate in?		
English	Welsh	Other (please specify):
No of people living at this address:		No of dependants living at this address:
Relationship of occupants to the carer:		

For Agencies Only:

Has the Carer provided consent for this referral and sharing their information with Carers Trust Crossroads Sir Gar? YES / NO

Referrer details:

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

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

By signing this form, I consent to Carers Trust Crossroads Sir Gar storing and using my personal information to provide a support service for me.

Signed (Carer): ________________________________ Date: ______________________

Telephone Referral: **Yes / No** (please circle)

Please return completed forms to:

Carmarthenshire Carers Information Service
The Palms
Unit 3
96 Queen Victoria Road
Llanelli
SA15 2TH

For further information, telephone: **0300 0200 002**

Email: info@carmarthenshirecarers.org.uk

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