West Cumbria Carers
Suite 7F,
Lakeland Business Park,
Lamplugh Road,
Cockermouth. CA13 0QT
Tel: 01900 821976
Fax: 01900 826206
Email:general@westcumbriacarers.co.uk

PLEASE FILL IN ALL INFORMATION. FILLING IN THIS FORM DOES NOT GUARANTEE A SERVICE.

DETAILS OF REFERRER			
Referrer (Name)	Organisation	Address/Tel.	Email
Enter text here	Enter text here	Enter text here	Enter text here

DETAILS OF YOUNG PERSON (OR SIBLINGS) BEING REFERRED							
Name	Date of birth	M/F	Ethnicity	Religion	Languages spoken	SEN?	Disability?
Click here to enter text.	Enter date	Choose item	Enter text here	Enter text here	Enter text here	Choose item	Choose item
Click here to enter text.	Enter date	Choose item	Enter text here	Enter text here	Enter text here	Choose item	Choose item
Click here to enter text.	Enter date	Choose item	Enter text here	Enter text here	Enter text here	Choose item	Choose item

Address	Telephone Numbers
Click here to enter text.	Click here to enter text.

Names of parents/guardians	Do they live with the young person?	Do they have parental responsibility?	Ethnicity	Religion	Languages spoken
Click here to enter text.	Choose item.	Choose item.	Enter text here	Enter text here	Enter text here
Click here to enter text.	Choose item.	Choose item.	Enter text here	Enter text here	Enter text here
Click here to enter text.	Choose item.	Choose item.	Enter text here	Enter text here	Enter text here

Which category does the young person belong to? (tick one)
School ☐ Training ☐ NEET ☐ Employed ☐ Other ☐

Number of siblings and position in family	Any other people living with the young person	School name and contact information (if at school)
Click here to enter text.	Click here to enter text.	Click here to enter text.

DETAILS OF PERSON WITH ILLNESS/DISABILITY			
Name	Date of birth (if available)	Relationship to young person	Illness/disability
Click here to enter text.	Enter date	Enter text here.	Click here to enter text.

REASON FOR REFERRAL (e.g. health, social, emotional, behavioural, learning, achievement, school attendance)
Click here to enter text.
NATURE OF SUPPORT GIVEN BY YOUNG CARER (e.g. emotional, physical)
Click here to enter text.
OTHER ORGANISATIONS OR SERVICES CURRENTLY OR PREVIOUSLY WORKING WITH THE YOUNG PERSON AND/OR FAMILY MEMBERS

Organisation providing support	Nature of Support
Click here to enter text.	Click here to enter text.

HAS AN EARLY HELP ASSESMENT BEEN COMPLETED?		
YES ☐	NO ☐	NOT KNOWN ☐
IF SO, PLEASE GIVE CO-ORDINATORS CONTACT DETAILS		
Click here to enter text.		
IS THE YOUNG PERSON CONSIDERED TO BE A CHILD IN NEED BY CHILDREN'S SERVICES SOCIAL CARE??		
YES ☐	NO ☐	NOT KNOWN ☐
IS THE YOUNG PERSON SUBJECT TO A CHILD PROTECTION PLAN?		
YES ☐	NO ☐	NOT KNOWN ☐

Is the Young Carer aware of this referral?	YES ☐	NO ☐
Is the Person with a disability/illness aware of this referral?	YES ☐	NO ☐

HOW DID THE REFERRER BECOME AWARE OF THE YOUNG CARERS PROJECT?
Click here to enter text.
WHAT IS YOUR RISK ASSESSMENT OF VISITING THE FAMILY ALONE?
Click here to enter text.
ANY OTHER INFORMATION
Click here to enter text.

FOR COMPLETION BY YOUNG CARERS ORGANISATION STAFF (office use only)	
Actions taken (initial contact/home visit/assessment etc)	Date undertaken