## **Young Carers' Service**

Supporting children and young people in their caring role

action	Building stronger families
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P	lease	comp	lete	and	return	to:
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Family Action 217 Maryon Road,			Email: g	Email: greenwich@family-action.org.uk					
Charlton, SE7 8DB			Tel: 0	Tel: 0208 853 9065					
Referrer Details									
Date of Referral	gency		Name o	Name of Referrer Occupation					
Agency Address:				<u> </u>					
Tel:				Email:					
Origin of Referral (P	Please Tick)			•					
Adult Mental Health	n A	dult Service	S	Childre	n's Services	School			
Self Referral	G	CC		Other (	(please specify)				
Referrals should be	shared wit	th the family	y and mad	e with their	agreement. Is the	e client / family	aware of the		
referral? Yes	No								
	PLE	ASE NOTE II	NCOMPLET	e referral	S MAY BE RETUR	RNED			
oung Carer's Details									
Family Name	First Nam	e(s)	Gender	D.O.B.	Ethnicity	Disability	Religion		
Current Address:			School / C	School / College:					
			Year:						
Young Carer's Conta	er:		Parent / Carer Name:						
Young Carer's Email				Relationship:					
Emergency Contact			Tel 1:	- <del> </del>					
Relationship:			Tel 2:						
Tel:			Email:						
ared for Person's De	tails								
Full Name		Gender	D.O.B.	Ethnicity	Employed / In	Education?	Religion		
Current Address if different from above: Relationshi					ip to Young Carer:				
		Contact I	•						

## Other Family Member Details (Please include details of Parent(s) / Carer(s) and siblings)

Full Name	M/	D.O.B	Ethnicit	Disabilit	Relationshi	Living	Employed / Attending	Religion
	F		у	у	p to child /	at	nursery / school /	
					YP	home?	college?	

Interpreter Neede	d?							
Yes	No	ıl L	Language					
Person(s) requirir	ng interpreter:							
Are you aware of	any Domestic Abus	se (curre	ent or historic	)?				
If yes, please giv	-	,		<i>,</i> -				
Are any of the chi	ldren (now or have	previo	usly been) pa	rt of the f	ollowing pla	ins:		
Type of Plan	Child Protection	Plan	Child in Nee	d (CHIN)	TAC		LAC	
Name (s)								
From – To								
Reason for Plan								
Is anyone in the fo	amily subject to Pr	obation	ı, a Communi	ty Sentenc	e or an Excl	usion Order?	•	
If yes, please giv	e details:			-				
Please list Profess	sionals/Agencies i	nvolved	and their co	ıtact detai	ls			
Title/Agency	Name			Address	<u> </u>	Tel	ephone	
GP								
Social Worker								
Support Worker								
School Contact								
Lead Professiona	ıl							
Other:								
Current Caring Ro	le / Responsibilitio	es (plea	se tick)					
Jobs around the house				Underta	king Persor	nal Care (was	hing/dressing etc)	
Financial Respon	sibilities			Keeping people safe				
Food Shopping				Looking after Siblings				
Helping with Communication				Looking	after self			
Other:								
Cared for Person's	s Difficulties (Pleas	e speci	fv)					
Illness:	,							
Disability:								
Mental Health D	iagnosis:							
Drug / Alcohol D	Dependency:							
Please aive detail	s of the Reason for	Referr	al					
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Please give details of your expectations of the work to be done

Please give details of any existing risks that we need to know about	
, ,	
Please attach any further relevant information. (inc: any Risk Assessments you have	e carried out)
Signature of Referred Person(s)	Date
Signature of Referrer	Date