



Referral form - Confidential

Please complete all sections you are able to

Name of Carer:

Address of Carer:

Telephone Number

Mobile Number

Email Address

Preferred method of contact [if specified]

Relationship to the person being cared for

D.O.B.

Gender:

Ethnicity:

Carers' GP Name & Address:

NHS Number:

Social Care ID [if known]

Disability/conditions/health concerns re Carer

Is the Carer aware of referral and given their consent? *(Please be aware that lack of Carer consent to referral means that we are unable to accept referral)*

Name of cared for:

Address of cared for (if different from above):

Telephone Number (if different from above):

D.O.B.

Gender:

Ethnicity:

GP Name & Address (If different from the Carers):

Brief details of the illness, disability or addiction of the person being cared for:

Other agencies/professionals involved

Is the cared for person aware of, and in agreement, with the referral? *(Lack of awareness and /or agreement will not affect our support to the Carer, but we will take additional care with contacting the Carer)*

Name and contact details of referrer

Date of referral

Expressed Need/Reason for referral

Any reason why a home visit by a lone worker may be inadvisable?

Any other information you would like us to be aware of

To make a referral, please email this form to CarersMaidstoneMalling@kent.gov.uk

Call 01622 685276 if you wish to discuss