Young Adult Carers 16 - 25 Referral Form

Please use **BLOCK CAPITALS** and ensure all boxes are completed.

Date of completion: **Completed By:**

PERSONAL DETAILS

First Name:		Date of Birth:	
Middle Name(s):		Biological Sex:	☐ Male ☐ Female
Surname:		Preferred Pronouns:	
Ethnicity:		NHS Number *(if known):*	
Home Address: Postcode:			
Preferred phone no:		Alternative no:	
Email:			
School / College / NEET status/ Paid work Voluntary work	…. … Under 16hrs ☐ 16 or more hrs ☐ Under16hrs ☐ 16 or more hrs ☐	GP Practice:	
Accommodation (as per Paris list)	Living with Friends and family permanently ☐ Living with friends and family temporarily ☐ Other ☐		
How would you, the young person, like to be contacted?	☐ At home ☐ At School/College ☐ Mobile ☐ Text ☐ Email ☐ Other:		

By providing us with your contact details, **you are giving us consent** to contact you via these methods.

REFERRAL DETAILS

Referred by (Name):		Job Title:	
Referrer's Organisation and Address:	Postcode:	Referrer's Phone no:	
		Referrer's Email:	
Referral Type:	☐ Self ☐ Family ☐ TYCS ☐ School / College ☐ Checkpoint ☐ CSW ☐ GP ☐ CIN/Safeguarding ☐ Children's Integrated Services ☐ Children's Early Help ☐ Job Centre Plus ☐ Careers SW ☐ Mental Health/CAMHS ☐ Drug/Alcohol ☐ Adult Health & Social Care ☐ Other Health ☐ Other: ……		
Is the person being referred known to Children's Services i.e. Child Protection or Children in Need? ☐ Yes ☐ No If **Yes, provide more detail on Page 3.**			

INFORMATION ABOUT THE CARING ROLE and FAMILY COMPOSITION

Who is the main person you are caring for?	☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Other: ……		
Are you the main carer?	☐ Yes ☐ No – If no, who is main Carer…….		
What difficulties does the person you care for have?	☐ Substance Misuse; ☐ Mental Ill Health; ☐ Elderly Frail; ☐ Dementia (including memory); ☐ Physical Disability;	☐ Learning Disability (including ADHD, Autistic SD, Behavioural); ☐ Sensory Disability; ☐ Long-term Illness or Condition; ☐ Terminal Illness ☐ Other ……..	
Details of Caring role (tick as many that are relevant to your caring role):	☐ Dressing ☐ Toileting ☐ Washing, Bathing and Showering ☐ Meal preparation ☐ Medication ☐ Shopping ☐ Cleaning ☐ Laundry ☐ Transferring on or off bed/bath/chair toilet ☐ Transport ☐ Mobilising indoors or outdoors ☐ Emotional Support ☐ Activities ☐ Managing Behaviour ☐ Looking after siblings ☐ Keeping safe ☐ Dealing with correspondence/finances ☐ Making calls/visit about or for them ☐ Other: ……		
Do you care for anyone else?	☐ Yes ☐ No	Who?	☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Other: ……

FAMILY COMPOSITION (who lives at home with you Mum, Dad, Brother, Sister etc):					*** Consent to Share F / P / N**
Surname	**First Name**	**Date of Birth**	**M / F**	**Relationship**	

****** Consent to share information: **(F) Full Consent (P) Partial Consent (N) No Consent**, to share information.*

OTHER SIGNIFICANT CONTACTS (Who else is important to you?):			*** Consent to Share F / P / N**
Full name	**Address**	**Relationship (Grandparents, Neighbour etc)**	

ADDITIONAL INFORMATION

Priority to be contacted. ☐ Urgent 1 week ☐ Important 2 - 3 weeks ☐ Less Urgent 3 – 6 weeks

Any Risks or Concerns. ☐ Yes ☐ No (please attach extra paper if necessary)

……

INFORMATION SHARING:

I agree that the information can be shared with health and social care professionals and service providers who can contribute to my care. I agree for information to be shared with my family if relevant.

Professionals: ☐ Yes ☐ No Family: ☐ Yes ☐ No

I do not wish my information to be shared with the following:

……

In the last week, how many hours of care do you estimate you have provided?

TOTAL Hours Caring per week. ☐ 1-7 hours ☐ 8-14 hours ☐ 15-21 hours ☐ 22-28 hours ☐ 29-35 hours ☐ 36-42 hours ☐ 43-49 hours ☐ 50+ hours

Please detail any other information below:

Would you like a copy of this referral? ☐ Yes ☐ No If yes, by paper or email? paper ☐ email ☐

Once completed, please send to:

Young Adult Carers, Torbay and South Devon NHS Foundation Trust, Paignton Library, Room 17 First Floor, Paignton Carers Centre, Great Western Road, Paignton, TQ4 5AG

Tel: 01803 208455 Email: torbayyac@nhs.net

FOR OFFICE USE ONLY:

(Form issued 2025)

Assigned Caseworker		**Date contacted:**	
YAC Number:		**PARIS No:**	
Caseworker advised of PARIS ID and YAC number and documentation processed and securely filed:			☐ Yes
If YAC would like copy of referral, has it been posted or emailed as requested:			☐ Yes