**Referral Form**

**Please return to:**

Sefton Carers Centre

27-37 South Road, Waterloo, L22 5PE

Tel: 0151 288 6060

Email: help@carers.sefton.gov.uk

|  |  |  |
| --- | --- | --- |
| Has consent been given by all parties below for this referral to be made and data to be shared?**NB: If consent has not been given, please do not complete the rest of this form** | **Yes** | **No** |
| **Carers Name:** | **Date of Birth:** |
| Is **English** the Carer’s primary language? **Yes No**  | If English is the Carer’s secondary language, can the carer speak English without the need for support? | **Yes No**  |
| Are there any other known reasons requiring support for effective communication? (I.E. British Sign Language). **Yes No** *Is yes, please explain under ‘Additional Information’*  | Is a language interpreter required to communicate with the Carer? | **Yes No** \**If yes, please state Carer’s primary language under; ‘Additional Information’* |
| Address: |
|  |
|  Postcode: |
| Carer Tel Number:   |
| **Cared For Name:** | **Cared for condition:** |
| **Please indicate (X) whether the Carer is a:** |
| **Young Carer:**(Under 18 yrs old and providing care) | **Parent Carer:**  (Parent/Guardian and carer of a child with additional needs)  | **Adult carer:** (18 yrs or older and providing care) |
| **Additional information / any known risk factors:**  |
| **Name of Referrer:**  | **Organisation:**  |
| **Contact Number:** | **Date:** |
| **Please note that if you are from a Living Well Sefton partner organisation you must make your referral using the IWS system as per the Living Well Sefton process.** |