**Cambridgeshire Carers Support Service**

Referral form

**Please email completed referral forms to C&Preferrals@makingspace.co.uk, or alternatively**

**please call 01480 211006 to speak to a member of the team.**

For more information about the support available please visit: www.makingspace.co.uk/support-for-carers/cambridgeshire-mental-health-carer-support

**1. Carer information:**

|  |  |
| --- | --- |
| **Title:** |  |
| **Full name:** |  |
| **Address:** |  |
| **Phone number:****By providing your phone number you are consenting to us contacting you by phone** |  |
| **Email:****By providing your email you are consenting to us contacting you by email** |  |
| **Date of birth:** |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Employment status:** |  |
| **Carer Type:** | E.g (sole, joint, mutual, parent) |
| **Your relationship with the person you care for:** | E.g (Spouse, sibling, parent- if the person you care for is under 18 please state their age) |
| **Disability/condition of person you care for:** |  |
| **Do you consider yourself to have a disability?** |  |
| **Do you have a first language other than English?**  | If so please state: |

**2. Cared For Information:**

|  |  |
| --- | --- |
| **Disability/condition of person you care for:** |  |
| **Does the person you care for live in Cambridgeshire?** | **YES**[ ]  **NO** [ ]  |

**3. Referrer information:**

|  |  |
| --- | --- |
| **Is this a self referral?** | **YES**[ ]  **NO** [ ] If yes, please go to section 4.  |
| **Name of referrer:** |  |
| **Organisation of referrer:** |  |
| **Email:** |  |
| **Contact Number:** |  |

**4. Support being referred for:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Advice and information** | **Emotional support** | **Groups / Activities** | **‘Emergency Support Plan’** |
| **☐**   | **☐**   | **☐**   | **☐**   |

**5. Any other relevant information:**

|  |  |
| --- | --- |
| **Please provide us with any other relevant information, details of the support required and information including potential risks:** |  |
| **Date of referral:** |  |