Peterborough Carers Wellbeing Service

Referral form

Please email completed referral forms to peterboroughcws@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/peterborough-carers-wellbeing-service

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)
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 Peterborough?	**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:

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