**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: makingspace.co.uk/support-for-carers/peterborough-carers-wellbeing-service

**1. Carer information:**

|  |  |
| --- | --- |
| **Title:** |  |
| **Full name:** |  |
| **Address:** |  |
| **Phone number:** |  |
| **Email:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Employment status:** |  |
| **Carer Type - sole, joint, mutual, parent:** |  |
| **Your relationship with the person you care for e.g. spouse, parent, sibling:** |  |
| **Disability/condition of cared for person:** |  |
| **Do you consider yourself to have a disability?** |  |
| **Do you have a first language other than English? If so, please state:** |  |

**2. Referrer information:**

|  |  |
| --- | --- |
| **Date of referral:** |  |
| **Is this a self-referral?** | Yes / No |
| **If no, please give the name of referrer?** |  |
| **Organisation of referrer** **(if relevant):** |  |
| **Referrer email:** |  |
| **Referrer contact number:** |  |

**3. Support being referred for (please tick):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Advice and information** | **Emotional support** | **Groups / Activities** | **‘What If’ plan** |
|  |  |  |  |

**4. Any other relevant information:**

|  |  |
| --- | --- |
| **Please provide us with any other relevant information relating to the referral including potential risks:** |  |