



# Care for Carers



## Enquiry Form

Date : \_\_\_\_\_

New Carer : Yes / No

Staff Member \_\_\_\_\_

Carer ID : \_\_\_\_\_

### CARER Information :

Title & Name : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Tel No : Home \_\_\_\_\_

Work \_\_\_\_\_

Mobile \_\_\_\_\_

E-mail Address : \_\_\_\_\_

D.O.B : \_\_\_\_\_

Gender : \_\_\_\_\_

Relationship : \_\_\_\_\_

Hidden Carer : \_\_\_\_\_

Referral Date : \_\_\_\_\_

Initial Contact Date : \_\_\_\_\_

Carer Status : \_\_\_\_\_

### REFERRAL Information :

Agency Name : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Postcode : \_\_\_\_\_

Contact Name : \_\_\_\_\_

Tel No : \_\_\_\_\_

Fax No \_\_\_\_\_

E-mail Address : \_\_\_\_\_

### Referral Reason :

- Stress Related                       Mental Health
- Physical Health                       Isolation
- Anxiety / Panic Attacks
- Carer Information
- Carer Support
- Other \_\_\_\_\_

### Enquiries :

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Benefits            | <input type="checkbox"/> Respite                  | <input type="checkbox"/> Housing            |
| <input type="checkbox"/> Support             | <input type="checkbox"/> Social Work              | <input type="checkbox"/> Health             |
| <input type="checkbox"/> Information         | <input type="checkbox"/> Learning Opportunities   | <input type="checkbox"/> One to One Support |
| <input type="checkbox"/> Telephone Support   | <input type="checkbox"/> Referral to other Agency | <input type="checkbox"/> Listening Ear      |
| <input type="checkbox"/> Add to Mailing List | <input type="checkbox"/> Other                    |   |

### Diagnosis Information Required :

- |                                   |   |                                     |  |
|-----------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Physical Disability    | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Neurological  |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Learning Disability    | <input type="checkbox"/> Multiple   | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Cardiac / Chest / Lung | <input type="checkbox"/> Alcohol    | <input type="checkbox"/> Frail Elderly |
| <input type="checkbox"/> Other    |   |                                     |  |

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