Crossroads CareNI
Young Carers

OFFICE USE ONLY
Ref No: _____
Priority: _____
Date Received: _____

YCS-C001-01

REFERRAL FORM

Date: _____

About the Young Carer

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____

_____ Age: _____

Postcode: _____ Phone No: _____

Parent/Guardian of Young Carer

Name: _____ Mobile No: _____

Relationship to Young Carer: _____ Landline No: _____

Email: _____

Preferred Method of Contact: ☐ Mobile No ☐ Landline No ☐ Email

General Practitioner of Young Carer

Name of GP: _____ Practice Name: _____

Address: _____

_____

_____

Postcode: _____ Phone No: _____

Does the Young Carer suffer from any medical conditions, disabilities or illnesses?
☐ Yes ☐ No If yes, please give details below:

_____

Is the Young Carer on any medication? ☐ Yes ☐ No If yes, please give details below:

_____

About the Situation

Type of care provided by the Young Carer: (please tick all that apply)

☐ Primary Carer ☐ Secondary Carer ☐ Domestic ☐ General Care
☐ Intimate Care ☐ Emotional Support ☐ Other Care

Please give details of Young Carers roles and responsibilities in and around the home:

_____

Any other relevant information: (e.g. attitude of care recipient, effect on life of young carer)

_____

Does the Young Carer receive help, support or activities from any other agency?
☐ Yes ☐ No
If yes, please specify:

_____

About the Care Recipient

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Date of Birth: _____

_____ Relationship to Young Carer: _____

Postcode: _____ Phone No: _____

Please give details of other family members / significant others, especially if under 18:

_____

Please give details of nature of illness / disability of Care Recipient:

_____

Does the Care Recipient receive help, support or activities from any other agency?
☐ Yes ☐ No
If yes, please specify:

_____

Person Referring

(*leave blank if self referring)

Name:* _____ Position /Relationship to Young Carer:* _____

Address:* _____ Phone No:* _____

_____

Postcode:* _____ Email:* _____

Type of Referral: ☐ Health Services ☐ Family / Relation ☐ Self ☐ Other, please specify:
☐ Social Services ☐ Voluntary Sector ☐ Education _____

Has a carers assessment been conducted? ☐ Yes ☐ No

Please return this completed form by: Email: ycarer@crossroadscare.co.uk
or Post: Young Carers, Crossroads Care NI, 7 Regent Street, Newtownards, BT23 4AB

Print Completed Form	Email Completed Form

Please Note: Crossroads will assess this referal based on the information submitted on this form. This will determine the referral's priority, as we do have a waiting list for our Young Carers Project.

028 9180 0661
www.crossroadscare.co.uk
ycarer@crossroadscare.co.uk
7 Regent Street, Newtownards, BT23 4AB

CrossroadsNI
DONATE ONLINE WITH JustGiving
NI Charity No: NIC102188