

Young Adult Carers Referral Form

Name	D.O.B	Ethnicity	Sex M / F
Address	Preferred phone number		
Postcode	Alternative number		
E-mail address	School / college	GP Practice	
Referral date:			
Referred by Self Yes <input type="checkbox"/> No <input type="checkbox"/>	Referrers Contact number		
Referred by member of the family Yes <input type="checkbox"/> No <input type="checkbox"/>	Referrers name:		
	Relationship to young person:		
	Contact details:		

How would you (the young person) like to be contacted? (circle)

At home / at school/college / Mobile / Text / E-mail / other...

Detail of caring role

Any other issues - please circle

Finance / Own health + wellbeing / Cared for persons Health + Wellbeing /
Education + training / employment + jobseeking / activities + support groups /

Breaks from caring / services + support / other.....

Part B - not compulsory

FAMILY COMPOSITION: people you (the young person) live with				
FAMILY NAME	1 ST NAME	DOB	M/F	RELATIONSHIP

OTHER SIGNIFICANT CONTACTS (Extended family and other parties)		
NAME	ADDRESS	RELATIONSHIP

Who is cared for? (circle)

Mother / father / brother / sister / grandfather / grandmother / other...

Any other information

Return completed Referral Form to: Young Adult Carers' Service, Carers Support Project, 11-12 Gelliwastad Road, Pontypridd, CF37 2BW.

Telephone: (01443) 281463 Email: youngcarerssupportteam@rctcbc.gov.uk

Office Use Only - Date contacted:

Reference Number: YAC.....

WCCIS Number: