**CARER’S DETAILS:**

Full Name:

Address: Postcode:

Tel No: Email Address:

Date of Birth:

Relationship to cared for person:

Living together with cared for person: Y / N

Does the carer have their own diagnosed mental illness: Y / N

If yes please provide diagnosis:

Has a Carers Assessment been completed? Y / N \*This is not required prior referral

Carers background information:

Marital Status: Religion & Belief:

Ethnicity: Sexual Orientation:

Any dependant children:

Does the person have any communication needs e.g. visual or hear impairment?

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**REFERRAL DETAILS:**

Date of referral:

Please circle the support required:

1-1 Support Group Support Information & Advice

Respite Funding Caring & Coping Course Telephone Support

Referral Priority Level: Low / Moderate / Urgent

Name of person making this referral and contact number:

Referring Organisation:

**CARED FOR PERSON DETAILS:**

Name: Date of Birth:

Currently being supported by a Dorset CMHT:

Primary Diagnosis:

Care Co-ordinator Name and Contact Number:

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**ADDITIONAL SUPPORTING INFORMATION:**

Is the Carer concerned about their own physical or mental health?

 Yes / No / Don’t know

Are there any concerns relating to the person they Care for?

Yes / No / Don’t know

If yes, is the Carer concerned that the person they care for may harm themselves or others?

Yes / No

If yes has been circled for any of these then please provide further relevant details here:

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Are there any known reasons why staff should not visit the Carer at home on their own?

Yes / No

Is the Carer happy for staff to leave voice messages on mobile or landline phones?

Yes / No / Don’t know

OFFICE USE ONLY:

Date referral received: Allocated MHRW:

Added to RIS: Y / N Referral scanned and attached to RIS: Y / N