

Carers Self Referral Form

The person I care for is:

- An older person
- A child
- Elderly mentally infirm person
- An adult with learning difficulties
- An adult with mental illness
- An adult with physical disability
- An adult with sensory disabilities
- A drug or alcohol misuser

Comments

Where did you pick up this leaflet?

Please note: all information received is confidential and is stored on computer

Name.....

Address

.....

.....

.....

Phone

Email

Would you like your doctor's surgery to know that you are a carer?

Yes No

Sign

Doctor's name

Surgery

Phone

Do you wish the above information to be added to your hospital records?

Yes No

Sign

Do you wish the above information to be added to the Carer Support Team's records enabling us to keep you informed?

Yes No

Sign