Devon Carers logo cmyk with tag line

**Devon Carers Referral from DPT**

Referrers Name:

Role / Team:

Contact number:

Email:

Date:

**Please Note: All fields are mandatory**

I confirm I have permission from the person named on this form to make this referral

I confirm I have permission from the person named to share information sensibly

with DPT staff if necessary

I confirm this individual provides unpaid care for a family member or friend who is ill, frail, disabled or has a mental health or substance misuse problem.

Is the cared for person aware of this referral?

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | Gender: |
| Address |  | | |
| Telephone Number |  | OK to leave a message?  *Messages cannot be left without carer consent* | |
| If not tel, method of contact |  | | |
| DOB |  | | |

|  |  |
| --- | --- |
| Concern:  What triggered the referral? |  |
| Cared-for situation:  Where does the cfp live?  Main condition? |  |
| Support in place:  e.g. support from another agency |  |
| Any concerns/issues regarding contacting the carer via telephone?  e.g. cared for unaware of the referral. |  |
| Any other risks that we need to be aware of? |  |

This carer requires additional support, ie Enabler, Translator, Advocate, if yes please explain:

**Please send completed form to** [devoncarers@nhs.net](mailto:devoncarers@nhs.net)