**Please Note: All fields are mandatory**

**Devon Carers Referral – NHS or DCC staff**

 Date:

|  |  |
| --- | --- |
| Referrer name: |  |
| Role/Team: |  |
| Contact number: |  |

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

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

|  |  |  |
| --- | --- | --- |
| Name |  | M / F |
| Address |  |
| Telephone number |  | OK to leave a message? [ ]  *Messages* ***cannot*** *be left without carer consent* |
| If no telephone, preferred method of contact |  |
| Carers Email address (optional) |  |
| DOB |  |
| What is the concern? Reason why an assessment is requested |  |

This carer requires additional support, ie enabler, translator, advocate,[ ]  if yes please explain

**For Hospital Discharge use only:**

I confirm there has been, or will be, an overnight stay in hospital [ ]

Date of discharge or expected date of discharge:

Hospital:

**Please encrypt the document with the password R3d5m@rt135 and send completed form to** referral@devoncarers.org.uk