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| **A blue circle with white text  Description automatically generated** | **Bristol Carers Service Referral Form** | |
| **1. Carer details** | | | | |
| Name and Surname | | |  | |
| Date of birth | | |  | |
| Email address: | | |  | |
| Contact phone number/s: | | |  | |
| Preferred method of contact: | | | Text  Phone  Email  Post | |
| Address & Postcode | | |  | |
| Name of GP surgery: | | |  | |
| Gender: | | | Female  Male  Non-Binary Gender fluid  Other  Prefer not to say | |
| Ethnicity: | | | **White:**  British  Irish  Other | |
|  | | | **Asian/Asian British:**  Bangladesh  Chinese  Indian  Pakistani  Other | |
|  | | | **Black/Black British:**  African  Caribbean  Other | |
|  | | | **Mixed:**  White Asian  White and Black African  White and Black Caribbean  Other | |
|  | | | **Additional:**  Arab  Other Ethnic Group  Prefer not to say | |
|  | | |  | |
| **2. Cared for person’s details** | | | | |
| Name and Surname | | |  | |
| Date of birth | | |  | |
| Address | | |  | |
| Care coordinator & Mental Health team | | |  | |
| MH condition or diagnosis | | |  | |
| Relationship to carer | | |  | |
| **3. Referrer’s details** | | | | |
| Date of this referral: | | |  | |
| Name: | | |  | |
| Service/Team: | | |  | |
| Phone number: | | |  | |
| Email address: | | |  | |
|  | | |  | |
| **4. Reason for referral** | | | | |
|  | | | | |
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| --- | --- |
| **5. Risks identified** (please complete at least one) | |
| Harm from others: |  |
| Harm to self: |  |
| Harm to others: |  |
| No risks identified |  |
|  |  |
| **6. Additional Information** | |
| Language needs? | If an interpreter is required, please state language(s) and gender preference: male / female / either. |
| Other needs/ disabilities |  |
| Any children under 18? (Please state age/s). |  |

Please return this form to[**bristolcarers@rethink.org**](mailto:bristolcarers@rethink.org)protected with a password agreed with us, or phone us on 0117 9031803. See more here [**www.rethink.org/bristolcarers**](http://www.rethink.org/bristolcarers)