# Carers in Bedfordshire Adult Carer Registration and Referral Form

**For CIB use only:**
**Staff member taking referral:** _____ Date form received or completed: _____
Referral source: ☐ Bedford ☐ Bedford Lounge ☐ Biggleswade ☐ Leighton Buzzard ☐ Luton Lounge ☐ Other
**Has welcome pack already been given/sent: Yes ☐ No ☐**

**How we use your information**
In order to support you we need to know some information about you. Carers in Bedfordshire will keep information about you confidential and will store your personal data securely in accordance with the Data Protection Act. We may be asked to share information we hold about you with the organisations who fund us (including Bedford Borough Council, Central Bedfordshire Council, Luton Borough Council and NHS Bedfordshire). We report this in such a way that does not name or identify you but helps provide important data so we can deliver and improve our services.

**Tick to confirm statement is understood and agreed** ☐

## About you - The carer

| | | | | |
|---|---|---|---|---|
| Carer's Title*: | | First Name*: | | Surname*: |
| Preferred name: | | Gender*: Male/female | Date of Birth*: | |
| **Carer type:** | ☐ Adult carer (you care for an adult)<br>☐ Parent carer (you care for an under 18yrs)<br>☐ Dementia/ Memory loss carer | | ☐ Former carer (you care for someone who is in residential care or has passed away)<br>☐ Veteran carer (you care for someone who was in the Armed forces 9)<br>☐ Unknown | |
| Your full postal Address<br>Postcode * | | | Email address: | |
| Telephone Numbers*: | | | **If you miss our phone call, can we leave a message**<br>☐ On voicemail?<br>☐ With someone else, if so, what is their name?<br>…… | |
| Home: | | ☐ preferred | | |
| Mobile: | | ☐ preferred | | |
| Do you give us consent to contact you in any of these ways: * | ☐ Email ☐ Post | ☐ SMS (text) ☐ Home number | ☐ Mobile | |
| Would you like to receive our information on our services by:<br>☐ Post ☐ Email ☐ SMS ☐ Home phone ☐ Mobile | | | Receiving help from other organisation<br>☐ Yes ☐ No<br>If yes, which agencies: | |
| Would you like to receive our quarterly magazine, *Carers by:*<br>Email ☐ ☐ Post | | | Any language needs/sign language?<br>☐ Yes ☐ No | |
| Would you like to be reminded about appointments by<br>☐ Phone ☐ Email ☐ SMS ☐ Post | | | Any other carers in the household? ☐ Yes ☐ No<br>If 'Yes' are they under 18*? ☐ Yes ☐ No | |
| Are there any risks we need to be aware (e.g. dogs, phobias) ☐ Yes ☐ No | | | **Your GP Surgery*:** | |
| Do you care for more than one person?<br>☐ Yes ☐ No<br>Do you consider yourself as having a disability?<br>☐ Yes ☐ No | | | | |
| How did you hear about CiB? | | | How long have you been a Carer? (Years) (Months) | |
| | | | Your ethnic origin: | Your faith/religion: |

*compulsory fields

## Carers in Bedfordshire

CONFIDENTIAL Registration Form

**About the person you care for.** We recommend you tell this person you're sharing this information with us. If you require help with this section, please call us on **0300 111 1919**.

| | | | |
|---|---|---|---|
| Cared For - Title: | | First Name: | |
| Surname: | | Preferred Name: | |
| Date of Birth of Cared For*: | | Relationship to Carer*: | |
| Address of cared for (if different to yours): | | | Borough ☐<br>Central ☐<br>Other ☐ |
| Primary Diagnosis*: | | | |
| | Are you the main carer for this person?* ☐ Yes ☐ No | | |

**To be completed only if cared for has dementia or memory loss**

| | | |
|---|---|---|
| If primary diagnosis is dementia, which form? | ☐ Alzheimer's Disease<br>☐ Mixed Dementia<br>☐ Frontotemporal<br>☐ Not known<br>☐ No diagnosis | ☐ Vascular Dementia<br>☐ Lewy Bodies<br>☐ Mild Cognitive Impairment<br>☐ Other |
| When diagnosed if known | Month: | Year: |
| If diagnosed, is person aware of the diagnosis? | ☐ Yes ☐ No | |
| Would you like to register the person with memory difficulties with the Navigation Service? | ☐ Yes ☐ No | |
| Any other diagnoses/conditions: | | |

**Additional information:** This helps us ensure we tell you all the services that might be available for you

| |
|---|
| |

## Referrer's details (to be filled in by professionals who are completing this form on behalf of a Carer)

| | | | |
|---|---|---|---|
| Referrer's Name: | | | |
| Organisation: | | Contact Number: | Mobile:<br><br>Landline: |
| Email address: | | | |
| Do you give us consent to contact you by: ☐ Email ☐ mobile ☐ landline ☐ Post ☐ SMS | | | |
| Do we need to contact you before we contact the Carer?<br>**Please ensure the carer knows you have asked us to contact them.** | | ☐ Yes ☐ No | |

*compulsory fields

## Carers in Bedfordshire

CONFIDENTIAL Registration Form

**Referrer Assessment of Carer's needs.** Please include specific reasons for referral, details of other agencies involved and interventions offered where appropriate.

Please send completed form to: Freepost RTTS-JLRZ-ZJZJ,

Carers in Bedfordshire, Suite K,
Sandland Court,
Brickhill Drive,
Bedford,
MK41 7PZ