Carers in Bedfordshire Adult Carer Registration and Referral Form

CiB Staff member taking referral: _____ Date: _____

You MUST fill in all the highlighted fields so we can process this registration.

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:	
*Date of Birth:		*Gender:	
*Your full postal Address (including postcode):	Borough ☐ Central ☐ Other ☐	Email:	

*Contact Numbers:		*Please tick	*If you miss our phone call, can we leave a message ☐ On voicemail? ☐ With someone else, if so, what is their name? .....
Home:		preferred	
Mobile:		preferred	

Do you give us permission to contact you by* : ☐ Email ☐ Post ☐ Mobile phone ☐ Home phone ☐ SMS

Would you like to receive our quarterly magazine called *Carers*? ☐ By email ☐ By post	Remind about appointments by ☐ Phone ☐ Email* ☐ SMS
Receiving help from other organisation ☐ Yes ☐ No If yes, which agencies:	Any language barriers/sign language? ☐ Yes ☐ No

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 ☐ Central ☐ Other ☐		
Primary Diagnosis*:			

*compulsory fields

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Any other diagnoses/conditions:	Are there any risks we need to be aware of? ☐ Yes ☐ No
Are you the main family carer for this person?	☐ Yes ☐ No
Do you care for more than one person?	☐ Yes ☐ No
Any other carers in the household?	☐ Yes ☐ No
If 'Yes' are they under 18?	☐ Yes ☐ No

Monitoring information - This helps us ensure that our services are accessible to everyone.

Your GP's Name :	GP Surgery:	
Your ethnic origin:		
Your religion or faith (if any):		
How did you hear about CiB? *		
How many years have you been a Carer?	(Years)	(Months)
Do you consider yourself as having a disability?	☐ Yes ☐ No	

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

If primary diagnosis is dementia, which form?	☐ Alzheimer's Disease ☐ Mixed Dementia ☐ Frontotemporal ☐ Not known ☐ No diagnosis	☐ Vascular Dementia ☐ Lewy Bodies ☐ Mild Cognitive Impairment ☐ Other
When diagnosed if known (month/year)		
If diagnosed, is person aware of the diagnosis?	☐ Yes ☐ No	
Does carer wish to be registered with the Navigation Service?	☐ Yes ☐ No	
Does person with memory loss wish to be registered with the Navigation Service?	☐ Yes ☐ No	

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

*compulsory fields

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Referrer's details – Partner agency and non-CiB staff to fill in this part if you are completing this form on behalf of the Carer.

Self- refer?	☐ Yes ☐ No If no, please complete below		
Referrer's Name:			
Organisation:		Contact Number:	
Email address:			
How would you like us to make contact with you? ☐ Email ☐ Telephone			

Do we need to contact you before we contact the Carer? **Please ensure the carer knows you have asked us to contact them.**	☐ Yes ☐ No
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

For CIB use only:

Entered on database by: _____ Date: _____

Date information pack sent if not done at referral: _____

Allocated to: _____ Task set or email sent: _____