



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:	<input type="checkbox"/> Adult carer (you care for an adult) <input type="checkbox"/> Parent carer (you care for an under 18yrs) <input type="checkbox"/> Dementia/ Memory loss carer		<input type="checkbox"/> Former carer (you care for someone who is in residential care or has passed away) <input type="checkbox"/> Veteran carer (you care for someone who was in the Armed forces 9) <input type="checkbox"/> Unknown		
Your full postal Address				Email address:	
Postcode *					
Telephone Numbers*:				If you miss our phone call, can we leave a message	
Home:		<input type="checkbox"/> preferred		<input type="checkbox"/> On voicemail?	
Mobile:		<input type="checkbox"/> preferred		<input type="checkbox"/> With someone else, if so, what is their name?	
Do you give us consent to contact you in any of these ways: *		<input type="checkbox"/> Email <input type="checkbox"/> Post		<input type="checkbox"/> SMS (text) <input type="checkbox"/> Mobile <input type="checkbox"/> Home number	
Would you like to receive our information on our services by: <input type="checkbox"/> Post <input type="checkbox"/> Email <input type="checkbox"/> SMS <input type="checkbox"/> Home phone <input type="checkbox"/> Mobile			Receiving help from other organisation <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agencies:		
Would you like to receive our quarterly magazine, <i>Carers by</i> : Email <input type="checkbox"/> Post <input type="checkbox"/>			Any language needs/sign language? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Would you like to be reminded about appointments by <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> SMS <input type="checkbox"/> Post			Any other carers in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' are they under 18*? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there any risks we need to be aware (e.g. dogs, phobias) <input type="checkbox"/> Yes <input type="checkbox"/> No		Your GP Surgery*:			
Do you care for more than one person? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you consider yourself as having a disability? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Central <input type="checkbox"/> Other <input type="checkbox"/>
Primary Diagnosis*:			
Are you the main carer for this person?* <input type="checkbox"/> Yes <input type="checkbox"/> No			

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

If primary diagnosis is dementia, which form?	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Vascular Dementia
	<input type="checkbox"/> Mixed Dementia	<input type="checkbox"/> Lewy Bodies
	<input type="checkbox"/> Frontotemporal	<input type="checkbox"/> Mild Cognitive Impairment
	<input type="checkbox"/> Not known	<input type="checkbox"/> Other
	<input type="checkbox"/> No diagnosis	
When diagnosed if known	Month:	Year:
If diagnosed, is person aware of the diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to register the person with memory difficulties with the Navigation Service?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: Landline:	
Email address:			
Do you give us consent to contact you by: <input type="checkbox"/> Email <input type="checkbox"/> mobile <input type="checkbox"/> landline <input type="checkbox"/> Post <input type="checkbox"/> SMS			
Do we need to contact you before we contact the Carer? Please ensure the carer knows you have asked us to contact them.		<input type="checkbox"/> Yes <input type="checkbox"/> 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