



**North Lanarkshire Young Carers
Project**

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Motherwell
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Nlyoungcarers@actionforchildren.org.uk

REFERRAL FORM

YOUNG CARERS INFORMATION

Name: _____ DOB: _____ Age: _____

Address: _____

Post Code: _____

Tel No: _____

Own Disability/Illness (if any): _____

Family Structure: (include age & d.o.b. where known):

School: _____

School Contact Person: _____ Tel No: _____

Young Carer's Consent: Yes ☐ No ☐

REFERRER'S INFORMATION

Name: _____ Tel No: _____

Address: _____

Post Code: _____

Email: _____ Relationship: _____

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INFORMATION REGARDING THE CARE RECEIVER

Name(s): _____ Tel No: _____

Address:

Post Code: _____

Relationship to Young Carer:

Illness/Disability:

DETAILED INFORMATION – THIS SECTION MUST BE COMPLETED

Is the young carers role as a: Primary carer ☐ Secondary carer ☐

Describe the nature and extent of the caring role:

Describe the impact which the caring role has on the young carer in terms of emotional and physical development and their opportunities for social / recreational activities:

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DETAILED INFORMATION – THIS SECTION MUST BE COMPLETED

Is the young carer in a situation which could increase the likelihood of them being looked after or accommodated (eg offending behaviour, outwith parental control, poor school attendance, substance misuse within the family or personal substance abuse).

Is the young carer subject to a supervision order / on child protection register?

YES

☐

NO

☐

If yes, please give a brief description of the reasons and length of time subject to this:

Is the young carer involved in any social / recreational activities:
(please describe and include days / times if member of a club)

Is the family in receipt of any additional support from other agencies?
(please give details)

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DETAILED INFORMATION – THIS SECTION MUST BE COMPLETED

In the light of the information provided, describe how you believe the project could best meet the needs of the young carer:

Are there issues within the family that the project could be involved in offering support with?

Referrer's Signature: _____

Date: _____

Office Use Only:

Date Referral Received: _____

Received By: _____

E-Aspire Form completed:

YES

☐

NO

☐