

Office use only
Reference No:

Care Service Referral Form
Carers Trust Tyne & Wear Crossroads Carer Services
The Old School, Smailes Lane, Highfield, Rowlands Gill NE39 2DB
Telephone: 01207 549 780 FAX: 01207 549 794
Email: info@carerstrusttw.org.uk



Eligibility Criteria: ✓ Provide regular and/or substantial level of care (eg. 20+ hours care per week and/or 5 visits per week)
✓ Be a resident in Gateshead

1. Referrer Details

Name of Referrer: _____ Date of Referral: _____
Address: _____ Telephone No: _____

2. Person with Care Needs Title: Miss/Mrs/Mr/Other

First Name(s): _____ Surname: _____
Address: _____
Postcode: _____ Telephone No: _____
Date of Birth: _____ Ethnic Origin: _____
Marital Status: _____ Religion: _____
Health Situation or Disability: _____

3. Carer Details Title: Miss/Mrs/Mr/Other

First Name(s): _____ Surname: _____
Address: _____
Postcode: _____ Telephone No: _____
Date of Birth: _____ Ethnic Origin: _____
Marital Status: _____ Religion: _____
Relationship to Person with Care Needs: _____
Carer Health Problems: _____

4. Summary of Home Situation

5. Summary of Care Needs (please give further details if required)

Mobility Issues: YES/NO

Personal Care: YES/NO

Behavioural Issues: YES/NO

Emotional Support Required: YES/NO

Care Package in Place: YES/NO (*If yes provide details*)

6. Describe Caring Role

7. Reason for Referral

8. Care Being Requested (Days and Times)

9. Professional Contact Names

GP Name:

Telephone No:

Social Worker:

Telephone No:

Other: