**Note: The referral to North Lanarkshire Carers Together, Carer Advocacy Service is for support in relation to the persons caring role.**

|  |  |
| --- | --- |
| **Date of Referral** | **Client Group *(Please mark with a √)*** |
|  | **Carer** |  | **If the person has a Disability, Mental illness, Dementia or is a young person under the age of 18, please speak to us about the most appropriate service for their Advocacy needs.** |

|  |  |  |
| --- | --- | --- |
| **Carer Details** | **Cared For Details** | **Current Location** ***(if not at home, ie Hospital & Ward)*** |
| **Name**  |  |  |   |
| **Address**  |  |  |
|  |  |
| **Postcode**  |  |  |
| **Tel.** |  |  |
| **DOB**  |  |  |

|  |
| --- |
| **Medical Details (If relevant)** |
| **Doctor** |  | **Consultant** |  |
| **Surgery** |  | **Hospital** |  |
|  |  |
| **Tel.** |  | **Tel.** |  |

**Note: Please complete the relevant boxes below based on the support needs of the Carer.**

|  |  |
| --- | --- |
| **Social Work Details (If relevant)** | **School Details (If relevant)** |
| **Social Worker** |  | **School Contact** |  |
| **Address** |  | **Address** |  |
|  |  |
| **Tel.** |  | Tel. |  |

|  |
| --- |
| **Please tick relevant existing services and contacts**CPN Social Worker District Nurse LAMH Care Home  Daycare Centre Memory Clinic MHCT AWI ASP Family/Friend/Self  |

**Note: Please complete the relevant boxes below based on the contacts above, if not already listed.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Contact** **Names** |  | **Contact** **Names** |  | **Contact** **Name** |  |
| **Address**  |  | **Address** |  | **Address** |  |
| **Tel.** |  | **Tel.** |  | **Tel.** |  |
| **Email** |  | **Email** |  | **Email** |  |

**Reasons for Referral for Advocacy**:

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|  |