**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**:

|  |
| --- |
|  |