

FCI Internal Use Only

CRM No.: _____
YCWM: _____

Date of intake: _____

Young Carer Details

1. Forename 2. Surname
3. Date of Birth 4. Mobile No.
5. Street Address
6. Email Address
7. School/College 8. Class/Year

Parent / Guardian Details

9. Forename 10. Surname
11. Landline No. 12. Mobile No.
13. Street Address (if different)

Person Being Cared For 1

16. Age (if known) 17. Relation to young carer
18. Disability, illness or reason for care
19. Is this person aware of the referral

Person Being Cared For 2 (if relevant)

20. Age (if known) 21. Relation to young carer
22. Disability, illness or reason for care
23. Is this person aware of the referral

Reason for Referral

24. Summary of situation/needs

Referral Made by

25. Forename 26. Surname
27. Title 28. Phone No.
29. Street Address
30. Email Address

Referral Information

31. Has this referral been discussed with the family and consent for same obtained? Yes No

Other Services/Agencies Involved

32. List other services and agencies involved.

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Caring Responsibilities (Tick as appropriate, and give a brief description)

33. Practical Tasks (e.g. cooking, housework & shopping)

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34. Physical Care (e.g. lifting, or helping with physiotherapy)

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35. Personal and intimate care tasks (e.g. dressing, washing, helping with toileting needs)

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36. Household management (e.g. budgeting, collecting social welfare and prescriptions)

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37. Child care (e.g. feeding, dressing, or washing younger siblings)

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Risk Indicators

This information is required to allow support staff to prepare for the assessment fully. Is there any history or evidence of the following?:-

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|--------------------|--------------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|
| 38. Aggression | Yes | No | Unsure | 39. Self Harm | Yes | No | Unsure |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Domestic Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41. Sex Offences | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

42. Please give further details (e.g. type of support required):-

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43. Are you aware of any danger associated with home visits? (e.g access to property, environment, animals etc):-

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