

Carer's Assessment Form

If you would like to expand on any of the questions, please use a blank page

Carer's details

Title	
Last name	
First name(s)	
Date of birth	
Gender	
Full address	
Postcode	
Daytime phone number	
Mobile phone number	
Your relationship to person you care for?	
What is your first language?	
Do you need an interpreter to help you with this form?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'yes', please tell us which language	
Do you have any religious or cultural needs that we should take into account?	
Do you want this information to be shared with the person you care for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you registered with a local support organisation for carers, such as Alzheimer's, BCASS, Barnet Carers Centre, FIN, Mencap, Jewish Care?	Yes <input type="checkbox"/> No <input type="checkbox"/> Please tell us the name of the local support organisation If no, would you like us to send you details of local support organisations for carers? Yes <input type="checkbox"/> No <input type="checkbox"/>
SWIFT Number <i>(office use only)</i>	

Cared for person's details	
Title	
Last name	
First name(s)	
Date of birth	
Gender	
Full address <i>(If different from your own address)</i>	
Daytime phone number	
Mobile phone number	
SWIFT Number <i>(to be completed by professional)</i>	
If more than one person, please add their details here.	

About the person you are caring for	
Please describe their condition, disability or illness	
<p>Are you involved in the planning of this person's treatment or care? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If 'yes', please give details below:</p>	

Current Situation - what help do you provide now? <i>Please give brief details</i>		Time spent per week (approx)
Help with personal care - e.g. feeding, washing, toileting, bathing or dressing.		
Help with taking medication		
Help with practical tasks shopping or cooking		
Help with communication		
Giving emotional support		
Help with paperwork		
Managing money		
Providing financial support		
Making sure the person is safe		
Help with mobility		
Providing or arranging transport		
Dealing with aggression, violence or verbal abuse		
Dealing with difficult behaviour.		
Dealing with crises		
Are there any other tasks or responsibilities? e.g. supervision, prompting, organising, advocating, taking responsibility, accompanying outside.		
Total time spent per week		

How does caring affect your life in the following areas? (optional) please give details

Work/Training/Study	
Leisure/social life	
Physical health	
Sleep	
Diet	
Emotional health (like stress)	
Relationships	
Opportunities	
Finance - do you need any help with finance?	
Safety/risks	
Respite/Breaks/Rest	
Holidays	
Accommodation	
Time for yourself	

Are you willing and able to continue to provide this level of care? Adult Social Services may be able to help you with this.

Yes No

If 'no', please give details.

Emergency / Contingency plan

What would happen in an emergency if you were ill or unable to care? What plans have you put in place?

Helping you in your caring role

What improvements do you want to achieve for yourself as a result of this assessment? What are your desired outcomes?

What advice, information, equipment or service would help you to improve the quality of your life and/or assist you in your caring role?

Further information

Anything else? – please use this space to add anything else which might support you to live the life you would like to

Equalities Monitoring Form

Barnet Council aims to provide high quality services that meet the needs of local people. We monitor the delivery of our services to ensure that it is representative and that all service users are treated fairly. In addition, we are legally committed to promoting race equality, under the Race Relations (Amendment) Act 2000, disability equality under the Disability Discrimination Act 2005 and gender equality from the Equality Act 2006 to everything the Council does. There is also some other legislation which instructs the council and other service providers to make sure that people are not prevented from accessing goods and services. Therefore, we need to ask these questions to make sure that we are delivering appropriate services to those people who need them.

The information you give on this form will remain strictly confidential, in accordance with the Data Protection Act 1998.

Disability	
Do you consider yourself to be a disabled person? Yes <input type="checkbox"/> No <input type="checkbox"/>	
What is your faith or belief?	
Buddhist <input type="checkbox"/>	Sikh <input type="checkbox"/> Hindu <input type="checkbox"/>
Christian <input type="checkbox"/>	Muslim <input type="checkbox"/> Jewish <input type="checkbox"/>
Agnostic <input type="checkbox"/>	Humanist <input type="checkbox"/> Jain <input type="checkbox"/>
Atheist <input type="checkbox"/>	Prefer not to say <input type="checkbox"/> Baha'i <input type="checkbox"/>
Any other religion <input type="checkbox"/>	If ticked, please specify:
Non-Religious Groups <input type="checkbox"/>	If ticked, please specify:
What is your gender?	
Female <input type="checkbox"/>	Male <input type="checkbox"/> Trans-gendered <input type="checkbox"/>
What is your ethnic group?	
Asian or Asian British: Indian <input type="checkbox"/>	A1
Asian or Asian British: Pakistani <input type="checkbox"/>	A2
Asian or Asian British: Bangladeshi <input type="checkbox"/>	A3
Asian or Asian British: Other <input type="checkbox"/>	A9
Black or Black British: Caribbean <input type="checkbox"/>	B1
Black or Black British: African <input type="checkbox"/>	B2
Black or Black British: Other <input type="checkbox"/>	B9
Chinese <input type="checkbox"/>	O1
Mixed: White & Black Caribbean <input type="checkbox"/>	M1
Mixed: White & Black African <input type="checkbox"/>	M2
Mixed: White & Asian <input type="checkbox"/>	M3
Mixed: Other <input type="checkbox"/>	M9
White: British <input type="checkbox"/>	W1
White: Irish <input type="checkbox"/>	W2
White: Other <input type="checkbox"/>	W9
Refusal <input type="checkbox"/>	NS
Other Ethnic Group <input type="checkbox"/>	O9
If other, please specify:	
What is your preferred language?	
Written	<input style="width: 100%;" type="text"/>
Spoken	<input style="width: 100%;" type="text"/>
Is an interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please indicate if you would prefer information in an accessible format, for example large print, Braille, audio tape, CD, Easywords © or pictorial format.	
<input style="width: 100%; height: 20px;" type="text"/>	

Your signature

Please sign and date below to indicate that this form is an accurate representation of your personal circumstances and that the facts you have given are correct to the best of your knowledge.

Carer's signature

Date

If you had help completing this form

If you have had help completing this form, the person who has filled it in must sign and date the form below stating their relationship to the applicant, or professional job title. Please provide your telephone number and give the reason why the applicant was unable to complete the form.

Signature

Date

Phone number

Relationship to carer

Reason carer did not complete form

Is the carer aware of this referral?

Confidentiality and information sharing.

The information you have given is confidential. It will only be shared with your permission.

Please sign here if you are happy for information on this form to be shared with other people who need to know.

Carer's signature..... Date

Please sign here if you are happy for information on this form to be shared with the person for whom you are caring, if they need to know.

Carer's signature..... Date .

Name of person completing this form (if different from above)

Relationship to carer

Address

Phone number

To be completed by health and social care staff following a discussion with the carer

Assessment of carers needs

(Including an assessment of the risk to the sustainability of the caring role. Is this Critical, Substantial, Moderate or Low)

Action plan to achieve carer's desired outcomes

Action	By who?
Referral to (please specify agency name) 1. _____ 2. _____ 3. _____ 4. _____	
Direct Payment for carer	
Referral to Welfare Rights Unit	
Break or respite care	
Advice / information	
Other	

Please return your completed form to the health or social care worker who gave it to you, or send it to:

- **For people over 65:**
Older Adults Duty Team, POST ROOM, Adult Social Services, North London Business Park, Oakleigh Road South, London N11 1NP
- **For adults with a physical or sensory impairment:**
Physical and Sensory Impairment Duty Team, POST ROOM, Adult Social Services, Building 4, North London Business Park, Oakleigh Road South, London N11 1NP
- **For adults with a learning disabilities:**
Learning Disabilities, POST ROOM, Adult Social Services, Building 4, North London Business Park, Oakleigh Road South, London N11 1NP
- **For people with a mental health problem:**
Primary Mental Health Team,
1st Floor, Berkley House, 18-24 High Street, Edgware HA8 7RP

Thank you for completing this form