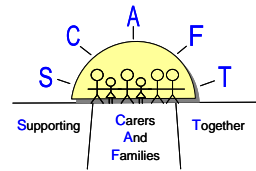


SCAFT YOUNG CARERS REFERRAL FORM

Tel no: 01268 741811

Email: info@scaft.org.uk



Childs Name:	
Address:	
Date of Birth:	
School attended:	
Parent/Guardian name & contact details: <i>(Home & mobile telephone numbers, email address...)</i>	
Agency referring & name of referrer:	
Reason for referral: <i>(Who does child help to care for? i.e. Parent/Sibling).</i>	
Are there any other agencies involved? <i>If so, please provide details.</i>	
Have any other assessments been completed? <i>If yes, please forward a copy.</i>	
Consent has been given by Parent/Guardian for the child/children named above to be referred to SCAFT and they understand the support offered by SCAFT. Yes* / No* (*please delete where appropriate).	
Name:	
Signature:	
Date:	

"All personal data/sensitive personal data are processed in accordance with the Data Protection Act 1998 – further details are available from The Secretary"