




## Introduction

If you care for someone regularly, you are entitled to a carers assessment. A carers assessment can help you carry on caring as long as you are willing and able to do so. Support services for the person you care for will be arranged to take into account your needs, views and preferences about what would be best for both you and the person you care for.

Your details will be treated in confidence. Please ask for assistance to complete the assessment form if you wish. A Social Worker, Community Care Worker, a friend or staff in the Carers Centre can help you complete the form.

Your Name _____	Date of Birth _____
Address _____ _____	 Home _____
Post code _____	 Work _____
	 Mobile _____
<b>Are you in employment or are you studying?</b> <i>(Please tick)</i>	
Employment	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not at all
Education	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not at all

<b>Pattern of care</b>		
How many days per week do you provide care?	_____	
On average how much time do you spend caring each day?	_____	
For how long have you been a carer?	_____	
Do you care for more than one person? <i>(Please tick)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have an alternative care arrangement if you become unable to care e.g. if you are ill, have an appointment etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please give details		
Would this arrangement be sufficient in an emergency situation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Single Shared Assessment  
**CARER'S ASSESSMENT**

**About you (Please only complete this part if you wish to do so)**

Do you have health problems? (*Please tick*) Yes  No

If yes, please describe them as fully as possible

If yes, what treatment (if any) are you receiving?

If you care overnight, how much care do you provide per night?

Is sleep affecting your caring role?

Yes

No

If yes, please give details.

Name and Address of your G.P. ....

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Single Shared Assessment  
**CARER'S ASSESSMENT**

Do you manage to have time for yourself to pursue your own hobbies and interests? <i>(Please tick)</i> How much free time per week do you have?	Yes	No
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<b>Continuing to Care:</b>							
Are you struggling to cope with your present level of support?						Yes	No
Do you need some help (or extra help) with caring?						Yes	No
Which of the following would help you to continue in your caring role? <i>(please tick all that apply)</i>							
Information		Aids and equipment		Help with shopping / cleaning			
Meals on wheels		Adaptations to home <i>(e.g. stair lift, wheelchair ramp)</i>		Help with bathing / dressing / toileting			
Help with nursing tasks		Training e.g. moving and handling		Help with lifting.			
Place at day centre for person you care for		Sitter service		Breaks from caring.			
Someone to talk to		Counselling		Support group			
Other <i>(please specify)</i>							
Which task would you like help with as a priority?							

Single Shared Assessment  
**CARER'S ASSESSMENT**

Which would be the next task you would like help with?		
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Would you like information about what other options would be available if you could no longer care? <i>(Please tick)</i>	Yes	No

<b>MONEY</b>		
Do you require information about benefits, including those for carers?	Yes	No
Would you like advice with paying of household bills, loans, Credit costs, rent, mortgage?	Yes	No
If yes, please give details.		

<b>Other Information</b>		
Do you have difficult feelings about your situation e.g. lonely/sad/angry/depressed/anxious/worried/guilty/other? <i>(Please tick)</i>	Yes	No

Single Shared Assessment  
**CARER'S ASSESSMENT**

Are you asked to share your views and ideas about the services provided for the person you care for?	Yes	No
Have you been able to influence the services delivered?	Yes	No
Are there any other issues you would like to raise? <i>(Please tick)</i> <i>Please give details</i>	<i>Yes</i>	<i>No</i>

Single Shared Assessment  
**CARER'S ASSESSMENT**

Regular caring for someone close to you can be rewarding but also sometimes, wearing. Do you want the opportunity to talk to someone about it?	Yes	No
Can we share this information with other agencies relevant to your assessment?	Yes	No
If yes, please complete the form below.		

**HOUSING AND SOCIAL WORK SERVICES**

**CONSENT FORM**

Name: ..... Tel. no. ....


Address: ..... E-mail address: .....  
.....  
.....

I agree to sharing the information disclosed in my carers assessment with other relevant agencies which may be approached on my behalf for information, advice or services.

Signature

Date

Single Shared Assessment  
**CARER'S ASSESSMENT**

<b>About the person you care for</b>	
Does the person you care for give you consent to share information?	Yes                      No
If 'Yes', please ask him/her to sign here:	
Signature of cared for person .....	Date .....
Name ( <i>Please print</i> ) .....	Date of Birth: .....
What is your relationship to the person you care for <i>e.g. son, daughter, husband, wife, mother, neighbour, other?</i>	
Do you live in the same house as the person you care for? ( <i>Please tick</i> ) Yes      No	
<i>If no, please give their address below</i>	
Address .....	 Home .....
Post code .....	

Single Shared Assessment  
**CARER'S ASSESSMENT**

Does anyone else live with the person you care for? ( <i>Please tick</i> )		Yes	No
If yes, do they help with the care?		Yes	No
Who else helps to provide care for your relative / friend? ( <i>Please tick</i> )			
sitter service		home care	
		personal carer	
			relatives
friends		neighbours	
		nobody else	
		other	
<i>Other (please specify)</i>			
How much help do you get each week? ( <i>Please tick in box</i> )			
none		less than 2 hours	
		2-5 hours	
		6-10 hours	
		more than 10 hours	
Are any of the following involved in the care of your relative / friend			
Doctor		district nurse	
		Occupational Therapist	
		Home carer	
social work - community care worker		community psychiatric nurse	Other
Who would you contact in an emergency out of hours?			

<b>Health</b>	<p>What health problem/s or disability does the person you care for have?</p>          
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Single Shared Assessment  
**CARER'S ASSESSMENT**

Do you need more information about their diagnosis/prognosis?

Yes

No

*(Please tick)*

*Please give details*

If you complete this form yourself, please return it to the professional person working with the person you care for or return to your local Social Work office.

*This page is for completion by the professional person working with the person you care for, or by a member of the local Social Work office.*

**Assessment Outcome Summary** (to be completed by key worker/professional)

**Recommendations:**

Single Shared Assessment  
**CARER'S ASSESSMENT**

**Record of unmet need**

**Signature** ..... **Date:** .....

Name (*Please print*) .....

*Job title* .....

*Office Address* .....

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