|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A logo with hands and a star  AI-generated content may be incorrect.  **Hidden Stars Referral Form** | | | | | | | | | | | | | |
| **Eligibility Criteria for Young Carers**  **To meet eligibility requirements for this project, the young person must be aged between 8 and 18, live in Torridge or Mid Devon, and provide care to a significant other who has been diagnosed by a medical professional with a terminal or a chronic illness that significantly impacts the life of the young person. To ensure information on this referral is accurate, please ensure it is completed with the young person present.**  **Where the referral form is not completed fully, or where eligibility criteria is not met, we regret that these referrals may be refused.** | | | | | | | | | | | | | |
| **Date of Referral:** | | **Referral Organisation:** | | | | | | | | | | | |
| **Referrers Name:** | | | | **Referrers Position:** | | | | | | | | | |
| **Referrers Email Address:** | | | | **Referrers Contact Number:** | | | | | | | | | |
| **Young Carer details:** | | | | | | | | | | | | | |
| **Surname of Young Carer:** | | **First Name/s of Young Carer:** | | | | | | | | | | | |
| **Date of Birth:** | | | | **Preferred Name of young carer:**  **Preferred pronouns:** | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | |
|  | | | | | | **Post Code:** | | | | | | | |
| **Contact number** | | **Email Address:** | | | | | | | | | | | |
| **Has the Young Carer/Parent/Guardian given permission for this referral?** | | | | | | | | | | **Yes** | | **No** | |
| **Parent/Guardian details:** | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | | | |
| **Address If different from above:** | | | | | | | | | | | | | |
|  | | | | | | **Post Code:** | | | | | | | |
| **Contact Number:** | | **Email Address:** | | | | | | | | | | | |
| **Please answer questions as fully as possible.** | | | | | | | | | | | | |
| **Is the Young Carer being supported by a Multi Agency Team (MAT)?** | **Is the family of the Young Carer being held at Early Help?**  **If Yes, please provide the Lead EH practitioner's name.** | | | | | | | **Have you identified any other concern with the Young Carer or their family that might be impacting the Young Carers wellbeing.** | | | | |
| **Social worker name & contact details (if applicable):** | | | | | | | | | | | | |
| **Please tick as many boxes as possible that are relevant. To your knowledge, has the Young Carer or their family had referrals into the following:** | **CAHMS:** | | **Devon Young Carers:** | | **Young Devon:** | | **SPACE:** | **Youth**  **Intervention Team:** | **FIT Worker:** | | **Domestic**  **Violence Support** | |
| **Hospice or Palliative Care:** | | **Other:** | | | | | | | | | |
| **Name of the Cared for person and relationship to the young carer?** | | | | | | | | | | | | |
| **Address of the cared-for person if different from the young carer:** | | | | | | | | | | | | |
| **Has the young carer had a Carers Assessment?** | | | | | | | | | **YES** | | **NO** | |
| **Please tell us about the support that the young carer requires:**    **I consent to this referral being completed on my behalf. Signature of young carer.....................................................................................**  **Thank you for completing this referral. Please email securely to:** [**imogen@ttvs.org.uk**](mailto:imogen@ttvs.org.uk)  **For any enquiries, please contact TTVS on: 01237 420130** | | | | | | | | | | | | |
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| **August 2025** | | | | | | | | | | | | |