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| 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** **For any enquiries, please contact TTVS on: 01237 420130** |
|  **Registered Charity Number 1125142. Company Limited by Guarantee. Registered in England 6577677** |
| **August 2025** |