

ABERDEENSHIRE CARERS SUPPORT SERVICE

REGISTRATION FORM Please complete and return to Wardes Road, Inverurie, AB51 3TT

For Office Use Only

Named Worker who completed form: _____

Date Registration details taken: _____

Quarriers Information given to Carer Please tick

CARERS DETAILS

Title: _____ Full Name: _____

Ethnicity: _____ Date of Birth: _____

Gender: _____ Email: _____

Address: _____

Post Code: _____

Tel No: _____ Mobile No: _____

Geographical Area: (*Please circle*): Aberdeenshire North/Central/South

Carer health Problems: Yes/No Please specify: _____

GP Name/Address of Practice: _____

Preferred contact method: (*Please circle*): Post/Telephone/Email

Are you in School/Further Education (*please specify name*): _____

As well as caring what other responsibilities to do you have? (*Please circle*)

Full timework (more than 16 hrs
Part time work (less than 16 hrs)
Voluntary Work

Family Commitments
Other: (*please specify below*)

DETAILS OF PERSON BEING CARED FOR

Name: _____ Date of Birth: _____

Address (if different from above): _____

Relationship to Carers: _____

Details of their health/medical issues:

REFERRAL DETAILS

How did you hear about Quarriers? _____

How were you referred for support (*please circle below*)

I referred myself

A friend helped me to access Quarriers support

I was referred in by another Professional

Professional's Name: _____ Job Title: _____

Name of Organisation: _____

Contact Address: _____

Contact Tel No: _____ Email: _____

DATA PROTECTION

All records relating to the Carers we support are held in accordance with the Data Protection Act (1998). We are committed to ensuring all personal data is accurate, stored securely and accessible to you on request. Full details of how Quarriers manages people's personal data is outlined in the Data Protection and Archiving Policy, which you can access on request.

I agree that Quarriers stores my information in accordance with the above statement

Signed: _____ Date: _____

I agree/do not agree (delete as appropriate) to allow my information to be shared with agencies involved in the provision of services for myself and the person I care for.

Signed: _____ Date: _____

Office Use only:

Worker allocated to case: _____ Date: _____

Data base file number allocated: _____