Carer's Self Assessment Form

If you help to look after a partner, relative, friend or neighbour who is frail or who has a health problem or a disability, you can ask for your own needs to be assessed. Please see our leaflet on carers which will be of help to you.

This Carer's Self Assessment form has been designed to help you access some of our general services for carers. The information you provide will be used to assess the level of support you need as a carer. If you have any queries or you would like help to fill in this form, please contact us on 01332 717777.

Please return this form to:
Carers' Breaks Information and Support Service,
Derby City Council,
Adult Social Services,
29 St Mary's Gate,
Derby DE1 3NU

1. Your details

Name _____ Date of Birth _____

Address _____

_____

_____

Postcode _____ Telephone No _____

Name of GP _____

Name and Address of Practice _____

_____

Adults, Health and Housing takes its legal responsibilities to protect people's privacy seriously. We will treat all information provided in confidence and in accordance with the Data Protection Act 1998. It will be used for the purpose of assessing your needs as a carer. We will only share information with others, if you have given us your written consent. It will not be shared with any other organisation or used for any other purpose. (See also the statement given on page 7 of this form.)

2. Are you…? Male ☐ Female ☐

3. Which of the following best describes your situation?
Please tick only one box – if more than one applies please tick whichever describes your main activity:

- ☐ In paid work full time
- ☐ In paid work part-time (30 hrs per week or less)
- ☐ Self Employed
- ☐ Student
- ☐ Looking for work / unemployed
- ☐ Retired from paid work
- ☐ Permanently sick or disabled
- ☐ Looking after home or family full-time
- ☐ Other (please specify)……

4. Over the last 12 months would you say your own health has on the whole been: ☐Good ☐Fairly Good ☐Poor

5. In the last week, how many hours of care do you estimate you have provided? (By care we mean providing support or assistance to someone in poor health, who has a disability or who is frail because of old age or who has problems related to substance abuse/addiction.)

☐☐☐ Hours of care in the last week

6. Please tell us what impact the care you provide has on your daily life. (Think about health, family & social life and any employment/education needs)

- ☐ My caring responsibilities have no negative impact on my daily life
- ☐ There is some impact on my lifestyle and leads to minor stress
- ☐ It has a big impact on my life: I am coping but need regular breaks
- ☐ It has a substantial impact on my life and I am not able to continue

7. How many people do you currently care for?

☐One person ☐Two people ☐Three or more people

8. How long have you been caring for this person/these people? (If you care for more than 3 people, please answer for the 3 you provide the most care for.)

	Person 1	Person 2	Person 3
Less than 6 months	☐	☐	☐
6 months to 2 years	☐	☐	☐
Over 2 years but less than 5 years	☐	☐	☐
Over 5 years but less than 10 years	☐	☐	☐
Over 10 years	☐	☐	☐

9. Is the person you care for …

	Person 1	Person 2	Person 3
Your spouse / partner	☐	☐	☐
Your parent / parent-in-law	☐	☐	☐
Your grandparent	☐	☐	☐
Your child or grandchild (aged under 20)	☐	☐	☐
Your adult child or grandchild (aged 20 or over)	☐	☐	☐
Another relative or family member	☐	☐	☐
Your friend / neighbour	☐	☐	☐
Other (please specify) … … … … … … … … … …	☐	☐	☐

10. Is the person you care for …

	Person 1	Person 2	Person 3
Under 16 years old	☐	☐	☐
Aged 16 – 19 years	☐	☐	☐
Aged 20 – 24 years	☐	☐	☐
Aged 25 – 64 years	☐	☐	☐
Aged 65 – 84 years	☐	☐	☐
85 years or older	☐	☐	☐

11. Please tick each of the following if it describes the person(s) you care for. The person you care for …

	Person 1	Person 2	Person 3
Has a physical disability	☐	☐	☐
Has a learning disability	☐	☐	☐
Has a sensory impairment	☐	☐	☐
Has a mental health problem	☐	☐	☐
Is frail and / or has limited mobility	☐	☐	☐
Has dementia	☐	☐	☐
Has a long term illness, is recovering from illness or is terminally ill	☐	☐	☐
Has HIV / AIDS	☐	☐	☐
Has problems related to substance abuse/addiction	☐	☐	☐
Has other needs (please specify below)	☐	☐	☐

12. The Caring Role – please tell us what help you provide for the person you care for: (If you care for more than one person, please give information about the person you spend the most time helping. Please tick all that apply. Use space at the end of the list to give us any other details.)

Help provided	**Daytime**		**Night-time**	
	Daily	**Occasionally**	**Daily**	**Occasionally**
☐ Personal Care (bathing, dressing)	☐	☐	☐	☐
☐ Help with taking medicines	☐	☐	☐	☐
☐ Giving emotional support	☐	☐	☐	☐
☐ Managing money	☐	☐	☐	☐
☐ Making sure the person is safe	☐	☐	☐	☐
☐ Providing / arranging transport	☐	☐	☐	☐
☐ Dealing with aggression / verbal or physical abuse	☐	☐	☐	☐
☐ Dealing with crisis / emergency situations	☐	☐	☐	☐
☐ Homecare tasks (laundry, cleaning, gardening)	☐	☐	☐	☐
☐ Cooking, shopping, providing meals etc	☐	☐	☐	☐
☐ Home nursing tasks (please specify below)	☐	☐	☐	☐
☐ Other help (please specify below)	☐	☐	☐	☐

Home nursing tasks: _____

_____

_____

Other help _____

_____

_____

_____

13. What extra support would improve the quality of your life? Please tick all that apply.

☐ More information about the illness of the person you care for

☐ Information about their medication, the benefits and the side affects

☐ Being fully involved in their treatment

☐ Knowing who to contact in a crisis

☐ Knowing what support is available in the community for you and the person you care for

☐ Time for yourself or a break from caring

☐ Help with caring tasks

☐ Other (please say what) _____

_____

14. Which of the above would be most valuable to you?

_____

15. Do you, or the main person you care for, get any help at the moment from:

	You	**The main person you care for**
Adult Social Services	☐	☐
Community Mental Health team	☐	☐
Independent Carer's organisation	☐	☐
District Nurse	☐	☐
Health Visitor	☐	☐
Home Care	☐	☐
Meals on Wheels	☐	☐
Voluntary Organisation (e.g. Age Concern, etc)	☐	☐
Social Worker	☐	☐

Social Worker's name (if known)

_____

Other (please specify e.g. family, friends, neighbours) _____ ☐ ☐

16. Please tell us here about anything that concerns you about your caring role, for example your health or support available.

_____

_____

_____

_____

17. We would like to contact you to discuss how we can support you as a carer. Do you agree to this?

☐ Yes ☐ No

18. We want local GPs to recognise the needs of carers when responding to their patient's health issues. Can we share your details with your GP?

☐ Yes ☐ No

19. We want to make sure that you, and the person (or people) you look after, get the help you are entitled to receive. **Please complete page 8 of this form, if the person (or people) you look after have given their permission for you to share their personal information with us.**

20. Please tick this box ☐ if you are happy for us to pass the information you have given in this form, anonymously, (your name, address and contact details will not be shared) to Leeds University. Derby City Council is a Department of Health Demonstrator Site for Carers Breaks. We are working closely with Leeds University to help gain a better understanding of the needs of local carers.

21. Please tick a box to indicate where you obtained this form.

☐ Your GP practice
☐ District Nurse
☐ Derbyshire Carers Association
☐ Website
☐ Voluntary Sector
☐ Other (please state) _____

22. Please tick this box ☐ if you are interested in our emergency planning service and you are happy for us to share your self assessment form with the emergency planning project officers from Derbyshire Carers Association.

For office use only:
Information and Advice Worker helped the carer to complete this form ☐

23. Please tick one of the boxes below to show your ethnic group

White:	Dual Heritage:	Asian or Asian British:	Black or Black British:	Chinese or other ethnic group:
☐White British	☐White & Black Caribbean	☐Indian	☐Black Caribbean	☐Chinese
☐White Irish	☐White & Black African	☐Pakistani	☐Black African	☐Gypsy / Roma
☐White Other	☐White & Asian	☐ Bangladeshi	☐Other Black groups	☐Other ethnic groups
☐Traveller of Irish Heritage	☐Any other Mixed background	☐Any other Asian background	☐Any other Black background	☐ Not declared

Your Signature _____ Date _____

Please return this form to:
Carers' Breaks Information and Advice Service,
Derby City Council,
Adult Social Services,
29 St Mary's Gate,
Derby DE1 3NU

Adults, Health and Housing takes its legal responsibilities to protect people's privacy seriously. We will treat all information provided in confidence and in accordance with the Data Protection Act 1998. It will be used for the purpose of assessing your needs as a carer. We will only share information with your GP, and share anonymous information with Leeds University, if you have given us your written consent. It will not be shared with any other organisation or used for any other purpose.

We will only use the personal information of those you care for to make sure they are receiving all the help they are entitled to. It will not be shared with any other organisation or used for any other purpose.

Please complete the following page/s, if the person/s you look after, has given their permission for you to share their personal information with us. A space has been provided for them to sign the form to indicate they have given their consent.

First Person Cared For

Name _____ Date of Birth _____

Address _____

_____ Ethnic Origin _____

Postcode _____ Telephone No _____

Your relationship to this person _____

I (*insert name*)…….. consent to my information being shared with Derby City Council's Adult Social Services

Signature……

Second Person Cared For

Name _____ Date of Birth _____

Address _____

_____ Ethnic Origin _____

Postcode _____ Telephone No _____

Your relationship to this person _____

I (*insert name*)…….. consent to my information being shared with Derby City Council's Adult Social Services

Signature……

Third Person Cared For

Name _____ Date of Birth _____

Address _____

_____ Ethnic Origin _____

Postcode _____ Telephone No _____

Your relationship to this person _____

I (*insert name*)…….. consent to my information being shared with Derby City Council's Adult Social Services

Signature……