

**Parent Carer Needs Assessment Record**

**Child/Young Person cared for:**

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| **Child/Young Person’s Name:**  | **D.O.B:** | **Gender: Male** |
| **Brief description of child/young person’s disabilities/difficulties:** |

**Carer’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Carer 1** | **Title:**  | **First Name:**  | **Second Name:** |

|  |  |
| --- | --- |
| **D.O.B:** | **Relationship to Child/Young Person:** |

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| --- |
| **Home Address;****Phone No:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Carer 2** | **Title:**  | **First Name:**  | **Second Name:** |

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| --- | --- |
| **D.O.B:** | **Relationship to Child/Young Person:** |

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| --- |
| **Home Address;****Phone No:** |

**Person completing this form:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Role :** |  |
| **Date Assessment Requested:** |  |

**Questions to consider: Carer’s Circumstances**

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| --- | --- |
| **Who do you care for?****How is your health?****How do you manage financially?****Do you think you home meets your family’s needs?****Who supports you?****Do you have back-up in a crisis?****What other Information would help you ?****Do you have contact with other parent carers?****What advice or training would be helpful?** **Money advice****Help with caring tasks/breaks****Things you would like to do** |  |

**Caring Tasks:**

|  |  |
| --- | --- |
| **The care tasks you need to do, day and night.****Are they different at weekends and school holidays?****NB: It may help to refer to your completed DLA form or care diary rather than repeat everything.** |  |

**Impact of caring on you:**

|  |  |
| --- | --- |
| **Tasks you enjoy.****Most distressing tasks (on a scale of 1 to 10).****Your relationship with the cared for child/young person.****Your relationship with other members of the household.****Have you had to give up anything due to caring?** |  |

**Services that are able to be provided by you/other agencies:**

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| --- | --- |
| **Note actions to be taken (by anyone) directly for the parent carer eg information to be provided, help with caring tasks at home.** |  |

 **What other support do you feel that you may benefit from?**

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| --- | --- |
| **What support could help you?** |  |

**How and when this plan will be reviewed:**

|  |  |
| --- | --- |
| **Note how the plan will be reviewed e.g as part of the child/young person’s care plan review. Also when the review is expected to take place.** |  |

**Signatures:**

|  |  |  |
| --- | --- | --- |
| **Carer 1** |  | **Date:** |
| **Carer 2** |  | **Date:** |
| **Worker** |  | **Date:** |