**REFERRAL FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| SELF REFERRAL (please tick box if appropriate)  | ¨ | PROFESSIONAL REFERRAL (please tick box if appropriate) | ¨ |
| **SERVICE USER DETAILS** |
| TITLE (Miss, Ms, Mrs, etc) |  |
| FIRST NAME |  |
| SURNAME/FAMILY NAME |  |
|  |
| DATE OF BIRTH (DD/MM/YYYY) |  |
| AGE |  |
|  |
| ADDRESS |  |
| POST CODE |  |
|  |
| CONTACT NUMBER |  |
| EMAIL ADDRESS |  |
|  |
|  |
| ETHNICITY (Please refer to Code index below. If Other, please specify) |  |
| CODE FOR ETHNICITY: BLACK/BLACK BRITISH AFRICAN (BA); BLACK/BLACK BRITISH CARIBBEAN (BC); BLACK/BLACK BRITISH OTHER (BO); OTHER (O)  |
| DISABILITY (Please refer to Code index below. Please specify diagnosis/condition) |  |
| CODE FOR DISABILITY: PHYSICAL (P); MENTAL (M); LEARNING (L) OTHER MEDICAL (OM) |
| TELL US MORE ABOUT YOURSELF: |
|  |
| CONSENT TO RELEASE AND SHARE INFORMATION: Read with service user / caregiver and answer any questions before obtaining signature. |
| The signature below serves to authorise that the service user understands that the purpose of the referral and disclosure of information to the agency listed above is for the purpose of ensuring the safety and continuity of care among service providers seeking to serve the service user. The referring agency has clearly explained the procedure of the referral to the client and has listed the exact information that is to be disclosed. By signing this form, the service user authorises this exchange of information. |
| SERVICE USER SIGNATURE AND DATE |  |
| **REFERRER DETAILS** |
| FULL NAME |  |
| ORGANISATION |  |
| EMAIL ADDRESS |  |
| CONTACT NUMBER |  |
| ADDITIONAL RELEVANT INFORMATION: |
|  |
| DATE |  |

|  |
| --- |
| OFFICE USE ONLY |
| PROJECT | WORKSHOP ¨ |  | ELDERS ¨ |
| ACCEPT  | ¨ |  |
| DECLINE | ¨ |
| IF DECLINED, REASON |  |
| DATE DECISION MADE: |  |