**IoA Service Referral Form**

**Section 1: Client Contact Details**

|  |  |  |
| --- | --- | --- |
| **Title** |  | |
| **First Name** |  | |
| **Surname** |  | |
| **Address** | 1.  2.  Town/City  County  Postcode |  |
| **Mobile** |  | |
| **Home Phone** |  | |
| **Any other contact info** | E.g. other phone numbers, email address | |
| **Gender** |  | |
| **DOB** |  | |
| **Age** |  | |
| **GP Name** |  | |
| **GP Address** | Surgery  1.  Town/City  County  Postcode | |
| **Next of kin or safety contact name and relationship to client** |  | |
| **Next of kin or safety contact details** | Tel. no.:  Address  Postcode | |

**We will contact the client as soon as possible and no later than 7 days of receiving this referral form**

**Section 2: Referral Information**

|  |  |  |
| --- | --- | --- |
| **Reason for referral** |  | |
| **Details of any relevant health condition and support needs** |  | |
| **Other supports in place** | Agency:  Name:  Address:  Tel: | Agency:  Name:  Address:  Tel: |

**This project offers a range of services; please tick below any which you / your client may be interested in**

|  |  |  |
| --- | --- | --- |
| **Counselling 🞏**  Up to 10 solution focused counselling sessions to help understand feelings around alcohol and triggers and how to manage these | **Mentoring 🞏**  Up to 12 personal sessions with a mentor who will assist with identifying practical ways to reduce and manage alcohol intake and build daily routine | **Personal Development Course 🞏**  12 week structured programme covering topics such as health, well-being, confidence building, and future planning. |

|  |  |
| --- | --- |
| **Please provide a few words on how you hope this project will help this person** |  |

**Section 3: Demographics**

|  |  |
| --- | --- |
| **Sexual Orientation** |  |
| **Religious Background** |  |
| **Relationship Status** |  |
| **Employment Status** |  |
| **Ethnicity** |  |
| **Country of Origin** |  |
| **Dependents 17 and under** |  |
| **Dependents 18 and over** |  |
| **Disabilities** |  |

**Section 4: Referral information**

|  |  |
| --- | --- |
| **First Referral for this client?** | **Yes / No** |
| **Referrer name and relationship to client** |  |
| **Referrer Address** | 1.  2.  Town/City  Postcode |
| **Referrer Tel No.** |  |
| **Referrer Email** |  |
| **Please give details of care plan, if any:** |  |
| **Can you share details of the client’s most recent assessment or care plan? Yes / No** | |
| **Would you like to be kept updated on this client? Yes / No** | |

**If sending this referral form via email, please send as a password protected document to ensure client confidentiality, using either the provided password or one of own choosing which can be emailed separately**