 **Referral Form**

**1.**

| Referrer name |  | If you are referring yourself please tick here ☐  **Go to Section 2** |
| --- | --- | --- |
| Job Title |  |
| Organisation |  |
| Email address |  |
| Telephone numbers | Landline: Mobile: | |
| **Personal information for the individual you are referring**  ☐ Please tick this box to confirm you have consent from the individual you are referring to share complete this referral and share the personal information in this form | | |

**2.**

| Name |  | | |
| --- | --- | --- | --- |
| Address |  | | |
| Telephone numbers | Landline: Mobile: | | |
| Date of birth |  | | |
| Emergency contact | Name: Relationship (ie. Parent, friend):  Phone no: | | |

**3.**

| What do you hope to gain by joining Grow for Life sessions? |  |
| --- | --- |
| Will you need any additional support at these sessions? *If Yes please give details* |  |
| Is there any other relevant information we should know? *E.G. important health information, learning difficulty, past experience, a criminal record* |  |
| How did you hear about Grow for Life? |  |

Grow for Life welcomes referrals for adults experiencing the following list, please tick those which you feel apply:

☐ Depression ☐ Anxiety ☐ Low confidence ☐ Isolation ☐ Autistic Spectrum Condition

Grow for Life will also review referrals for other conditions on a case-by-case basis. Please indicate which of the following may also apply to the individual:

☐ Addiction recovery \* ☐ Bereavement ☐ Trauma

(\* Please note that we are not able to accept referrals for individuals still in active addiction)

☐ Other mental health condition(s) or other reason(s) for referral - please give details:

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Signing this form gives permission for Grow for Life to hold the data contained in this form

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_