**Art Ease - Referral Form**

**(email form to info@knowlewesthealthpark.co.uk)**

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| --- | --- | --- |
| **Date:** | | |
| **I am referring myself ⬜** | **Agency Referral ⬜**  Name: Position:  Organisation:  Contact number: | |
|  | | | |
| **CLIENT NAME:** | | | |
| **Date of Birth:** | | | **Gender: Male/Female/Transgender** |
| **Address** *(including postcode):* | | | |
| **Telephone no.** *(please provide two, if possible):*  **H**ome**: M**obile | | | |
| **GP** *(name and surgery):* | | | |
| **Availability** *(groups run on a Tuesday and Wednesday mornings)* | | | |
| **Do you have any special needs/disabilities we need to be aware of? YES ⬜ NO ⬜**  If yes, please specify: | | | |
|  | | | |
| **Brief reason for wanting service:-** | | | |
| **How did you find out about our services** | | | |
| **Do you attend any other projects or are you involved with any other service at present?**  **YES ⬜ NO ⬜ If YES, please provide details:**  Name of service(s):  **If yes, would they be happy for us to make contact to find out how our services might fit with other things they are doing?**  Contact person: Telephone no: | | | |

**PLEASE COMPLETE CONSENT OVERLEAF/……**

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| **Are you able to get to us?** |

**Confidentiality and Data Protection (to be completed with KWHPC staff)**

**I have completed this form and agree with its contents being shared with the Knowle West Health Park Company and the service delivery staff.**

Client’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** Knowle West Health Park Company operates a secure system of holding information. The personal details on this form are not passed to any other external organisations, or given to funders. Information is used in an anonymized form to report to funders on how well our services work (it contains no individually identifiable information)

**PLEASE RETURN COMPLETED FORM TO: SUE COOKE, at info@knowlewesthealthpark.co.uk**