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**Art Ease - Referral Form**

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| **Date:** | | |
| **I am referring myself ⬜** | **Agency Referral ⬜ (please make sure you put your name and contact number or we**  **won’t be able to accept this 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:**  **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?**  **Name of service(s): Contact person: Telephone no:** | | | |

**PLEASE COMPLETE CONSENT OVERLEAF/……**

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| --- |
| **Are you involved with any mental health teams?**  **YES ⬜ NO ⬜**  **If YES, Do you have a Care Plan? YES ⬜ NO ⬜** |
| **Are you able to get to us?** |

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

**I have completed this form or I am aware that this referral has been made on my behalf 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 anonymised form to report to funders on how well our services work (it contains no individually identifiable information)

**PLEASE RETURN COMPLETED FORM TO:**

**Art on Referral**

**Knowle West Healthy Living Centre**

**5 Knowle West Health Park**

**Downton Road**

**Bristol**

**BS4 1WH**

**Or email form to: info@knowlewesthealthpark.co.uk**