Empowering Communities and individuals to reach their full potential in life

Helping Hands Agency Referral Form

This section to be completed by referring agency and sent by post or email to

The Sandycroft Centre, West Avenue, Smallwood, Redditch. B98 7DH

Tel: 01527 595135 Email: info@sandycroft.org

REFERRER CONTACT DETAILS	**CONTACT DETAILS OF SERVICE**
Name:	Name:
Agency: Referral date:	Address: Post Code:
Agency address: Postcode: Telephone No: Email:	DOB: Age: Contact No: Email: Any disabilities or additional needs? **YES / NO** If yes, please explain:

Will referrer accompany new service user? **YES / NO** Is the service user comfortable using the English language? **YES / NO** If not, which language do they usually use?	Please indicate availability *i.e.., morning or afternoon appointments are preferred and any days to avoid*

Other relevant household members

Name	Age	Date of Birth	Relationship

Please provide any health / medical information that we should know about, this would include medication, existing diagnoses or restrictions to your mobility.

Please tick the services you would like support from

- ☐ **Counselling**
- ☐ **Domestic Abuse**
- ☐ **Family Services**
- ☐ **Family Violence**
- ☐ **Mental Health**
- ☐ **Courses**
- ☐ **Support Groups**

Reason for referral plus background info

Any indication that this person poses a risk to herself or others, including staff? **YES / NO**

If yes, please explain

Please share any risk assessments in respect of this person (e.g. MARAC)

Are there any child safeguarding issues or legal sanctions in place? **YES / NO**

If yes, please attach relevant documents

Are you are signing on behalf of a child under the age of 16: ☐ Yes ☐ No

Name of parent/Guardian________________________________

Sign your name of parent/guardian________________________

Who will be collecting the Child? ___________________

Any known Allergies, if so, what are they? _______________________________________

Date of signature ____________________

Name of Worker____________________________

Signature of Worker_________________________

Job Role of worker__________________________

Date of signature___________________________

Date started course______________ Date completed course_____________

Equal Opportunities Form

The information from this form is used only for statistical reporting.
No personal information which can identify a client will be shared externally.

Gender		**Sexual Orientation**		**Disability**	
Female		Heterosexual / Straight		Physical Impairment	
Male		Gay / Lesbian		Sensory Impairment	
Non-Binary		Bisexual		Mental Health Condition	
Transgender		Other		Learning Need	
Prefer not to say		Prefer not to say		Long-Standing Illness	

Age													
0-15		**16-25**		**26-35**		**36-45**		**46-55**		**56-65**		**65+**	

Ethnicity								
White		**Mixed**		**Asian**		**Black**		**Other**
British		Black African & White		Bangladeshi		African		
Irish		Black Caribbean & White		Indian		Caribbean		
Northern Irish		White Asian		Pakistani		Other		
Gypsy				Chinese				
Traveller				Other				
Other								

Religion or Belief							
Atheism		Islam		Judaism		Christianity	
Buddhism		Jainism		Hinduism		Sikhism	
Other							