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| HOUSING ADVOCACY SUPPORT SERVICE REFERRAL FORM | | |
| date of referral  Click or tap to enter a date. | Referral received by: (office use) | reference number: (office use) |

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| referrers details: | | |
| Name of referrer:  Position:  Please tick if self-referral | Address: | Mobile Number:  Office Number:  Email: ​ |

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| details of person being referred: | method of contact: |
| Name:  Date of Birth: Click or tap to enter a date.  Address:  Contact Number:  Email:  Ethnicity:  Gender:  Religion:  Please gain consent form the person you wish to refer.  Has the person consented to this referral?  Yes  No | Face to Face: Yes  No  Landline/Mobile: Yes  No  Email: Yes  No  Does the person have communication needs?  Yes  No  If yes, what are they?  First Language:  Is there a language barrier?  Yes  No  If yes, what is the barrier? |

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| disability details |
| Does the person have disability or long-term health condition: Yes  No  If yes, please tick appropriate box  Learning Difficulty: Mild  Moderate  Complex  Severe  Profound  Neuro Diverse:  Please explain:  Mental Health Difficulty:  Please explain:  Physical Difficulty:  Please explain:  Sensory Impairment:  Please explain  Other - please explain:  GP details: |

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| Describe any risk associated with home or contact |
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| Service involvement |
| Other services involved with the referred.  1.  2.  3.  4. |

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| Reason for referral |
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Please email completed form to[sandwelladvocacy@btconnect.com](mailto:sandwelladvocacy@btconnect.com)

Please call **0121 520 8070** if you would like to discuss this referral

Postal Address: Sandwell Advocacy, 28 Wood Street, Tipton, West Midlands, DY4 9BQ