**Date of Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has consent for this referral to be made been given: Verbal/Other: Yes No**

**If “No” please indicate why?**

|  |  |
| --- | --- |
| **Person Referred:**  **Name and title:**  **DOB: Age:**  **Address:**  **Tel: (H)**    **(M)**    **Email:**  **Preferred method of communication** | **Referred by:**  **Name:**  **Relationship to Client:**  **Address:**  **Tel:**  **Email:** |
| **Does the Person Live Alone/Have Any Regular Visitors or Carers?**  **(If YES provide details below)** | |
| **Name:**  **Relationship:**  **Tel (*if different*):** | **Name:**  **Relationship:**  **Tel: (*if different*):** |
| **Nature of Impairment** (Please note Possability People’s Advocacy Service supports adults with a physical and/or sensory impairment, including people who are D/deaf or hard of hearing. Unfortunately we are unable to support individuals whose primary impairment is Autism or Asperger’s Syndrome – please contact us if you have any queries about making a referral to our service)  **Risk Assessment/Any lone Worker Issues?** | |

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| --- |
| **Any Communication or Access Requirements?**  **Reason for Referral** |

|  |
| --- |
| **Further Information** |

**Please return to; Possability People,** **Montague House Montague Place, BN2 1JE.**

**Tel. 01273 89 40 40/45** [**voice@possabilitypeople.org.uk**](mailto:voice@possabilitypeople.org.uk)

**Date this referral received: \_\_\_\_\_\_\_\_ By Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date inputted to database: \_\_\_\_\_\_\_\_ By Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**