 Referral Form

| Referrer name |  |
| --- | --- |
| Organisation |  |
| Job Title |  |
| Email address |  |
| Telephone numbers | Landline: Mobile: |

| Trainee name |  |
| --- | --- |
| Address |  |
| Telephone numbers | Landline: Mobile: |
| Date of birth |  |
| Gender |  |
| Emergency contact | Name: Phone no:  Relationship (ie. Parent, friend): |

| What do you hope for the individual to gain by joining the GfL sessions? |  |
| --- | --- |
| Will the individual need any additional support at these sessions? |  |
| Does the individual represent a risk to a mixed group of men and women? |  |
| Is there any other relevant information we should know? |  |

**Personal information for the individual you are referring**

☐ Please tick this box to confirm you have consent from the individual you are referring to complete the referral and provide the personal information requested in this form.

Grow for Life welcomes referrals for adults experiencing the following list, please tick those which you feel apply to the individual

☐ Depression ☐ Anxiety ☐ Low confidence ☐ Isolation ☐ Autism

Grow for Life will also review referrals for other conditions on a case-by-case basis. Please indicate which of the following may also apply to the individual:

☐ Addiction recovery \* ☐ Bereavement ☐ Trauma

(\* Please note that we are not able to accept referrals for individuals still in active addiction)

☐ Other mental health condition(s) or other reason(s) for referral - please give details:

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Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referrer signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_