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**Referral Form**

|  |  |
| --- | --- |
| Full Name |  |
| Organisation |  |
| Job Title |  |
| Address & Postcode |  |
| Email Address |  |
| Telephone Number | Landline: Mobile: |

**Referrer Information**

**Personal Information for the Individual you are Referring**

|  |  |
| --- | --- |
| First Name |  |
| Surname |  |
| Address & Postcode |  |
| Phone number |  |
| Gender |  |
| Emergency Contact | Name: Phone number:  Relationship (e.g. friend, parent, support worker): |
| Does the individual need any additional support? |  |
| Does the individual represent a risk to a group? |  |
| Does the individual represent a risk to a mixed group of men and women? |  |
| Is there any other information we should know? |  |

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 low confidence, anxiety, depression or isolation. Please indicate which of the following apply to your client:**

Depression  Anxiety  Low Confidence  Isolation

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

Recovery from addiction  Bereavement  Trauma

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

Other mental health condition(s) and/or another reason for referral. Please give details below:

Click or tap here to enter text.

|  |  |  |
| --- | --- | --- |
| Full Name | Signature | Date |

**For the Referrer: Please name, sign and date to complete your referral**