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| **Adult Referral Form** | | | | | | | |
| Please use this form to make a referral for someone else. If you are making a referral for yourself please use our **Self-Referral Form.**  The person being referred will not be open to our service until a practitioner has been allocated to them post-triage. In order to do this we need all sections of the form to be fully completed. If you do not provide adequate information we will be unable to progress to triage and the Adult Referral Form will be sent back to the referrer for completion.  Fully completed Adult Referral Forms can be sent to us by email: [referral@togetherwe.uk](mailto:referral@togetherwe.uk) or by post: Together We CIC, De Lucy Centre, Market Place, Egremont, CA22 2AF | | | | | | | |
| **Your details** | | | | | | | |
| **Name:** | |  | | | | | |
| **Organisation:** | |  | | | | | |
| **Job Title or Relationship to the person being referred:** | | | | | |  | |
| **Contact Number:** | |  | | **Email:** | |  | |
| **Referral details** | | | | | | | |
| **Name:** | |  | | | | | |
| **Contact Number:** | |  | | | **Date of Birth:** | |  |
| **GP Surgery:** | |  | | | **NHS Number**  **(if known):** | |  |
| **Email:** | |  | | | | | |
| **Advocate / Nominee name (if applicable):** | | | | | | | |
| **Advocate / Nominee contact number (if applicable):** | | | | | | | |
| **Address:** |  | | | | | | |
| **Preferred method of contact:** | | | [ ] Phone call, [ ] Text message, [ ] Email, [ ] Letter | | | | |
| **Please give brief background information and the reason for your referral:** | | | | | | | |
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| **Has the individual been referred to another organisation? If so, which organisation(s)?** | | |
|  | | |
| **Risk assessment** | | |
| **\*\*\*THIS SECTION MUST BE COMPLETED WITH ANY HISTORICAL OR CURRENT RISK \*\*\*** | | |
| **Please provide details below of any risk assessment or attach DICES assessment to the referral email:** | | |
|  | | |
| **Safeguarding concerns:** | | |
|  | | |
| **Name of professionals already involved:** | **Contact phone number / email:** | **Agency** |
|  |  |  |
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**Please return your completed form by email to:** [referral@togetherwe.uk](mailto:referral@togetherwe.uk)   
**or by post to:** Together We CIC, De Lucy Centre, Market Place, Egremont, CA22 2AF

**FORMS WILL BE RETURNED TO THE REFERRER IF INADEQUATE INFORMATION IS PROVIDED**

**IF THERE ARE IMMEDIATE SAFEGUARDING CONCERNS OR RISK CONCERNS, IT IS THE RESPONSIBILITY OF THE REFERRER TO CONTACT THE APPROPRIATE SERVICE**

**Please be aware that Together We CIC do not maintain responsibility for a client’s risk whilst in service with us, we would ask that the GP or statutory team continue to accept that responsibility. We will however continue to update and manage risk throughout our interactions.**

**If you need any further information, please do not hesitate to contact us on 0808 196 1773**