CCAWS
Community Care and Wellbeing Service
Gwasanaethau Gofal Cymunedol a Lles

For Office Use Only

Date received: Completed by: Entered by:

Client Code: Scanned:

Referral Form

Please complete this form using the your/the client's details and note that if completing it on behalf of someone else, you must have their permission to do so.

Title: Dr Full Name: _____ Date of Birth: _____

Address: _____ Postcode: _____

Is it ok to write to the client at this address? Yes Email address: _____

Home telephone: _____ Mobile: _____

Is it ok to leave a message on these numbers? Home: Yes Mobile: Yes

First language: _____ Second language: _____ Preferred: _____

Religion: _____ Ethnicity: _____

Disabilities/special requirements: _____ Health concerns:

Number of children: _____ Ages: _____ Disabilities/special requirements:_____

GP Name: _____ Surgery Address: _____

Telephone: _____

Referee Name: _____ Organisation:_____

Relation to client: _____ Telephone: _____

Address: _____ Postcode: _____

Emergency Contact Name: _____ Address: _____

Postcode: _____ Telephone: _____

Relation to client: _____

Services requested:	Advocacy	Befriending	Counselling	Support Group
	☐	☐	☐	☐

What are your concerns? How can we help you?

Are there any risks/dangers that we need to be aware of?

Have you used our services before? No

Would you prefer a male or female support worker? Male

Availability (counselling and befriending only)

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Morning	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐

Data Protection

I understand that my information will be kept on a secure database until it is no longer required to assist me or required by law. I give permission for CCAWS to contact me via: telephone ☐ email ☐ post ☐

I understand there is a privacy policy I can see if I wish.

Signature:

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Risks Identified: _____