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# Referral Form

# (For agencies)

Thank you for your interest. The information you provide will enable us to assess whether this is a suitable service for the person you are referring and may be shared with the person you are referring.

|  |  |
| --- | --- |
| Name of the person you wish to refer |  |
| Address |  |
| Telephone |  |
| Date of birth: / /  |
| Does this person know you are referring her / him?☐ Yes ☐ No | Is it okay for us to contact this person directly?☐ Yes ☐ No | Does this person have children?☐ Yes ☐ No |
| How long have you known the person you are referring, and in what capacity? |
| Brief reason for referral:  |
| Your name |  |
| Name of organisation/ team) |  |
| Contact Number & Email |  |

FIRST LANGUAGE:

Language support required. YES NO

If YES, please give details:

|  |
| --- |
| If relevant, please tell us about any risk factors we should be aware off (e.g mental health difficulties/mental wellbeing) |
|  |

If you have any other information that you wish to be known or feel is relevant, please do let us know.

Statement: I have spoken to the person named above and they have agreed that I release this information to the BME Suffolk Support Group. The person named above has agreed to the BME Suffolk Support Group contacting them directly.

Referred by (please print): ……………………………… Organisation: ………………………………

Signature: …………………………………………….…... Date: ……………………………………….

Referrer’s contact telephone number: ………………………………………………………………….

## A L L I N F O R M A T I O N I S C O N F I D E N T I A L