**Referral Method:** Tel [ ]  / Visit to WEB [ ]  **/** Post [ ]  / Email [ ]

**Service Required**: Activity based services [ ]  /Relaxation [ ]  / Confidence Building Course [ ]  1:1 Listening Service [ ]  / Pamper therapies [ ]  / Counselling [ ]  / Early Help Support for Families [ ]

Name of Woman Referred:

Date referred:D.O.B

Address/Post Code:

Home Phone Number:Mobile Number:

Can message be left on home phone? Yes/No. Can message be left on mobile/by text? Yes/No

Can we write to you at your home address? Yes/No

GP Name & Address:

Emergency Contact Name: Tel No.:

**I agree to this referral being made on my behalf to WEB: (Verbal consent can be given if over phone)**

**Name: Signature:**

Please give a short summary of the reason for referral:

Is support needed for any of the following issues? Please tick all that apply:

Isolation [ ]  Physical Health [ ]  Domestic Violence [ ]  Debt [ ]  Parenting [ ]

Mental health [ ]  Depression [ ]  Stress [ ]  Confidence [ ]  Relationship Breakdown [ ]  Sexual Assault/Abuse [ ]  Carer [ ]  Other [ ]

Willing to attend group induction (please note this may reduce appointment waiting time) [ ]

Referred By: Agency:

Contact Details: Signature:

Risk Assessment: Low [ ]  Medium [ ]  High [ ]

Risk Management:

Please take a moment to complete the following form with the client. This information is **vital** to existing and future funding and **ensures our ability to provide these services.**

**Date of Birth **

**Gender at birth:** Male**[ ]** Female**[ ]  Preferred Gender:** Male **[ ]** Female **[ ]**

**Ethnic Origin**

**White Asian Black Other Ethnic Group**

British [ ]  British [ ]  British [ ]  Arab [ ]

Irish [ ]  Indian [ ]  African [ ]  Mixed Background [ ] Other [ ]  Pakistani [ ]  Caribbean [ ]  Other [ ]

Gypsy/Irish [ ]  Bangladeshi [ ]  Prefer not to say [ ]

Traveller

Other [ ]  Chinese [ ]

**Religion or Belief**

No religion [ ]  Christian [ ]  Buddhist [ ]  Hindu [ ]  Jewish [ ]

Muslim [ ]  Sikh [ ]  Other Religion [ ]  Prefer not to say [ ]

**Sexual Orientation**

Heterosexual [ ]  Lesbian [ ]  Gay [ ]  Bisexual [ ]  Prefer not to say [ ]

**Crime**

Victim of a crime [ ]  Offending background [ ]

**Disability Caring Responsibilities**

Does you have any physical disabilities? Do you have any caring responsibilities?

Yes: [ ] No:**[ ]** Yes: [ ] No: [ ]

Do you have any learning difficulties? Do you suffer from any visual impairment?

Yes: [ ] No: [ ] Yes: [ ] No: [ ]

If you have answered yes to any of the questions, do you require any support at WEB? Please specify.