

## Referral for Support

Personal Details							
<b>Applicant Full Name:</b>							
<b>Title: e.g. Mr, Mrs etc</b>				<b>Gender: e.g. Male / Female</b>			
<b>Also Known As:</b>				<b>Date of Birth:</b>			
<b>Contact Address of Applicant:</b>							
		Postcode:					
<b>Main Phone Number(s):</b>							
<b>Email Address:</b>							
<b>Preferred methods of contact: e.g. email/ text/ phone call</b>							
Current Accommodation Type							
LA/HA Tenancy		Private Tenancy		Owner Occupied		With Family/Friends	Supported Housing
B&B/Homeless		Hostel/Refuge		Hospital		Other:	

Health and Support:	
<b>Please tell us your mental health diagnosis or provide a brief description of your mental health issues.</b>	
<b>Please tell us about any physical health problems, if you have any.</b>	
<b>Please tell us about any risks that we might need to be aware of to ensure we provide the best support e.g. risk to self, risk to others.</b>	(If you have an existing risk assessment please attach it with this application)

Please indicate the service or type of support you require	
<b>Community Housing Support Service</b>	<b>Yes / No</b>
One to One support if you are at risk of losing your tenancy or independence as a result of poor mental health. <b>Please tell us about the housing problems you are experiencing:</b>	
<b>Recovery &amp; Social Inclusion - Community Links Service:</b>	<b>Yes / No</b>
One to One support for people who are isolated and unsure how best to take their first steps towards engaging with their local communities. <b>Please tell us about the social isolation you are experiencing:</b>	
<b>Recovery &amp; Social Inclusion - Outreach Service:</b>	<b>Yes / No</b>
An exciting programme of conservation / heritage projects running in four different locations, each one day per week, around the county. Sessions also available in our mechanics workshops in Devizes. Duration is typically 4 months per individual. <b>Please tell us what you think would appeal to you about group / practical projects.</b>	

Signatures and Referrer Information	
<b>Client Signature:</b>	<b>Date:</b>
If Self Referral please tick and state where you heard about Richmond Fellowship: <input type="checkbox"/>	
<b>Referrer Signature:</b>	I confirm that I have discussed this referral with my client and I have their permission to submit it to Richmond Fellowship <b>Date:</b>
<b>Referrer Name:</b>	
<b>Address:</b>	
<b>Telephone:</b>	<b>Email:</b>

**Please return to: Richmond Fellowship, Office H, Unit 1A, Bath Road Business Centre, Bath Road, Devizes SN10 1XA.**

**Email: [wiltshirereferrals@richmondfellowship.org.uk](mailto:wiltshirereferrals@richmondfellowship.org.uk). Tel: 01380 724833**