We ask that referrals are made with your client’s consent and that you speak to them about referring to us. It can be difficult to speak about their experiences, and this needs to be done when they feel ready to. By submitting this form you are confirming that you have received the explicit consent of the client to make a referral.

We will contact the client directly to speak with them to discuss this referral and arrange an introductory meeting. Please try to provide us with at least two methods of contact. We will attempt to contact the client through as many methods as possible and will stop trying if we don’t manage to get in contact within a month.

**Referrer Details**

|  |  |
| --- | --- |
| **Organisation** | Click here to enter text. |
| **Name** | Click here to enter text. |
| **Contact number** | Click here to enter text. |
| **Contact email** | Click here to enter text. |
| **Date** | Click here to enter text. |

**Client Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Click here to enter text. | **Date of birth** | Click here to enter text. |
| **Area** | Choose an item. | | |
| **Address** | Click here to enter text. | | |
| **Contact number** | Click here to enter text. | **Email** | Click here to enter text. |
| **Contact permissions** | Text  Email  Voice message  Identify ourselves | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Looking for (mark all that apply)** | **Support** |  | **Advocacy** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has the client been referred to us before** | **Yes** |  | **No** |  | **Unsure** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Availability during week days** | **Morning** |  | **Afternoon** |  |

|  |  |
| --- | --- |
| **Evening** |  |

|  |
| --- |
| Brief Reasons for Referral |
| Click here to enter text. |
| Is there any risks factors we should make aware of? Please comment |
| Click here to enter text. |

|  |
| --- |
| **Accessibility or other difficulties** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mobility** |  | **Vision** |  | **Hearing** |  |
| **Speech** |  | **Literacy** |  | **Childcare** |  |
| **Dependant Care** |  | **Transport** |  | **Language (which)** |  |
| **Other** | Click here to enter text. | | | | |

Please return this referral by email to: [support@wrasac.org.uk](mailto:support@wrasac.org.uk)

Or post to:

WRASAC, Referrals, Sangobeg House, 4 Francis Street, Dundee, DD3 8HH

Helpline 01382 201 291

For more information about any of our services you can contact our Business Line on (01382) 205556

[**www.wrasac.org.uk**](http://www.wrasac.org.uk)