community solutions

Participant Referral Form

Details of Person Requiring Support

First Name: ..... Middle Name: ..... Last Name: .....

Title: ..... Date of Birth: ..... Gender: Male ◯ Female ◯ Other ◯

Address: .....

..... Postcode: .....

Home Telephone Number: ..... Mobile Number: .....

Email address: .....

Area of Support Please tick the area of support required.

Mentoring/Befriending ☐	Family Solutions ☐	Work Placement ☐
Practical ☐	Volunteering ☐	Employment Support ☐
Groups ☐	Training ☐	

	Name	Age	School
Additional Household Members Adults & Children			

White	English / Welsh / Scotish / Northen Irish / British	◯
	Irish	◯
	Gypsy or Irish Traveller	◯
	Any other White Background	◯
Mixed / Multiple Ethnic Group	White and Black Caribbean	◯
	White and Black African	◯
	White and Asian	◯
	Any other Mixed / Multiple Ethnic Background	◯
Asian / Asian British	Indian	◯
	Pakistani	◯
	Bangladeshi	◯
	Chinese	◯
	Any other Asian Background	◯
Black / African / Caribbean/ Black British	African	◯
	Caribbean	◯
	Any other Black / African / Caribbean Background	◯
Other Ethnic Group	Arab	◯
	Any other Ethnic Group	◯

Referrer Details

Name: ..... Agency Name: .....

Address: .....

Postcode: ..... Contact Number(s): .....

Email: .....

Other Information

Is the person an ex-offender	Yes ○	No ○
Have they ever served in the Armed Forces	Yes ○	No ○
Has anyone in their family ever served in the Armed Forces	Yes ○	No ○
Does the person have a Disability?	Yes ○	No ○
Are there any risk factors for this person?	Yes ○	No ○

If yes, please state risk factors below:

Health Needs

Reason for Referral:

I confirm that the individual outlined in this document has given verbal consent to refer to Community Solutions and for their details to be forwarded to relevant partner agencies, if additional needs are identified. ***Please initial the box to confirm***.

Date: ..... Initial:

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