

Details of Person Requiring Support

Title: First Name: Last Name:

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	Groups	Volunteering
Practical	Training	Employment Support

Equal Opportunities

White - British	Mixed - White & Asian	Asian	Black
White - English	Mixed - White & Black	Asian - British	Black British
White - Gypsy or Irish traveller	African	Asian - English	Black English
White - Irish	Mixed - White & Black	Asian - Scottish	Black Scottish
White - Scottish	Caribbean	Asian Welsh	Black Welsh
White - Other White (specify if you wish)	Mixed - Other White &	Bangladeshi	African
	Chinese	Chinese	Caribbean
	(specify if you wish)	Indian	
		Pakistani	Prefer not to say

Other (specify if you wish)

Referrar Details

Referrer Name: Agency Name:

Address:

.....

Postcode: Contact Number(s):

Email:

Reason for Referral (What support does this person require)

Additional Information

Is this person an ex-offender? Yes No
(If **YES** please provide details)

Are there any Barriers/Risks for this person? Yes No
(e.g. Unemployment, Isolation, Drug/Alcohol issues)

Health Needs Yes No
(Are there any Health Issues Mental or Physical)

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:

