Please complete this referral form to the best of your knowledge and return it to:

Referrals@womenshealthmatters.org.uk **with password protection**

|  |  |
| --- | --- |
| **WHM Project referred to:**  |  |
| **Details of the person being referred** |
| Name: |  | Date of Birth: |  |
| If under 16, is parent/carer aware of the referral? | [ ]  Yes [ ]  No |
| Is this person known by any other name?  |  |
| What do they prefer to be called?  |  |
| Address: |  |
| Postcode: |  |
| Does this person live alone? If not, please provide details of who they live with.  |  |
| Type of Property | Local Authority | Housing Association | Owner |
| Temporary Accommodation | Living with Friends/Family | Refuge/Hostel |
| Other (Please specify) |
| Can we send post out to this address? | [ ]  Yes [ ]  No |
| Contact Number: |  |
| If not the contact number of woman, please include name and relationship to woman |  |
| Can we text this number? | [ ]  Yes [ ]  No |
| Can we leave a voicemail on this number? | [ ]  Yes [ ]  No |
| Will they answer a withheld number? | [ ]  Yes [ ]  No |
| **Children** |
| Name | DOB | Who do they live with |
|  |  |  |
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|  |  |  |
| Is the woman currently pregnant? | [ ]  Yes [ ]  No |
| If yes, please provide EDD: |  |
| Are Children’s Social Work Services currently involved? | [ ]  Yes [ ]  No |
| If yes, please provide details: |  |
| Please provide contact details for allocated social worker:  |  |
| **Reason for Referral** |
| Please provide as much detail as possible as to why you are making this referral.*If referring for support around DVA, please indicate whether this is historic/ongoing/both, whether the woman is still in the relationship etc. Consider what support would be beneficial and the outcomes the woman would like to see.*  |
|  |
| Are there any risk factors you are aware of *(living with perpetrator, mental health, housing/social circumstances, other risks within the home etc.)* |
|  |
| Any access issues (*interpreter, physical accessibility, learning disability, creche needed etc.)* |
|  |
| **Other Workers** |
| Is the woman currently working with any other agencies? | [ ]  Yes [ ]  No |
| If yes please provide details: |
| Name | Role | Organisation | Contact Details |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
| **Refer Details** |
| Name: |  |
| Organisation: |  | Role: |  |
| Email Address: |  | Telephone Number: |  |
| Where did you hear about us?  |  |
| **Data Protection** |
| By submitting this form, I confirm that the woman named has consented to a referral being made to Women’s Health Matters [ ]  |
| I confirm that I have explained to the woman being referred that Women’s Health Matters will be receiving, storing and using the information given on this form and she has consented to this (referral cannot be accepted without this) [ ]  |
| Referrer’s signature: |  |
| Client’s signature(where possible to obtain): |  |
| Date: |  |