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| --- | --- |
| **Client Name:**  **Gender:**  **DOB:**  **Contact Number:** | **Postal Address:**  **Email Address:** |
| **Name of Agency:**  **Name of Worker:**  **Contact Number:** | **Referral Date:**  **Email Address:** |

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| **Brief explanation of treatment history:** *(Please include information on time in treatment, substitute prescribing, illicit use, alcohol use, motivation and any other relevant information to aid this referral)* |
| **Risk Assessment:***(Where necessary, please give a brief outline of any possible safeguarding risks or other concerns)* |
| **Areas of interest:** *(Please tick as appropriate)*   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Volunteering (SUIT) |  | Housing |  | Training |  | | Volunteering |  | Advocacy |  | Debt |  | | Activities |  | Employment |  | Benefits |  | | Group Work |  | Education |  | Other |  |   Other (Please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Declaration of consent:** *(Please tick if appropriate)*   |  |  | | --- | --- | | I have given consent to this referral being made to access support provided by SUIT |  |     **Signature:** (Staff) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature:** (Client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please send completed referral form to** [SUIT@wolverhamptonvsc.org.uk](mailto:SUIT@wolverhamptonvsc.org.uk)