

Community Connector Referral Form

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| **Name:** |  | **Date of Birth:** |  |
| **Phone:** |  | **Gender****(please circle)** | Male / FemalePrefer not to say |
| **Email:** |  | **NHS Number** |  |
| **Address:** |  |
| **Type of Referral****(Please complete one of these shaded columns)** | **ORGANISATION/SERVICE**Name / role of referrer and include details of previous contact | **INDIVIDUAL** Name/ relationship to person being referred eg Family/ friend/ neighbour) | **SELF REFERRAL**Tell us how you found out about “Community Connector” |
| **Consent obtained:**  | YES/ NO | YES/ NO | Not applicable |
| **Signature and date** |  |  |  |
| **Reason for Referral** (include relevant history and any risks or challenges to be aware of) |
|  |
| **What outcomes would you like to see from this referral to the Community Connector?****Please tick box or state under “Other”** |
| Reduced social isolation - feeling better connected with the local community |  |
| Improvements to lifestyle – feeling healthier, fitter, and happier |  |
| Relevant advice or information accessed in order to address presenting issues. |  |
| Improved confidence and self esteem |  |
| New or existing skills developed with potential opportunities for volunteering/ employment |  |
| Prevented or reduced the need for clinical intervention or statutory support services |  |
| Other (please state) |  |

**Please send this form to our secure inbox:** **communityconnector@suffolkfamilycarers.org**