

Community Connector Referral Form

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| **Name:** |  | **Date of Birth:** |  | |
| **Phone:** |  | **Gender**  **(please circle)** | Male / Female  Prefer 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**](mailto:communityconnector@suffolkfamilycarers.org)