

Who is making this referral?

Self-referral Where did you hear about Oakleaf?
 Have you had a show around in the last 3 months? Yes No

Referred by someone else Referrers name:
 What organisation they work for:
 Their work address:
 Their contact number:

Personal information

Name: _____ Date of Birth: _____

Address: _____

Email: _____

Contact number/s: _____

If supported name of consultant/CPN/support worker:	Support workers contact telephone number: Can the support worker be contacted directly if necessary? YES <input type="checkbox"/> NO <input type="checkbox"/>
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What would the client like to change or achieve by attending Oakleaf?

- 1.
- 2.
- 3.

What is the client's long term goal?

GDPR STATEMENT:

Oakleaf Enterprise are the Data Controller of the information you have provided. Due to the nature of our work with you, we are required to collect personal data about you which will include special categories of personal information This information will only be collected from you and used by us to assist you, it will not be shared with third parties unless the law allows. We have a data protection regime in place to oversee the effective and secure processing of your data, we will hold your information for 6 years unless you instruct us to delete it once the relationship has ended. We would like to be able to send you information and /or reminders about activities and appointments by post, telephone email and/or SMS. If you agree to being contacted in this way please sign below.

Name: _____ Date: _____

PLEASE TURN OVER TO COMPLETE THE REST OF THE FORM



Mental health information Please give us as much information as you can regarding the client's mental health conditions and how they affect them

Current mental health information:

Past mental health information:

Reason for referral What would the client like to do at Oakleaf and why?

Please specify which activity/activities the client is interested in:

Vocational Training

Upholstery IT Horticulture

Social Inclusion Activities (see calendars for activities)

Please circle the area(s) in which you would like to join activities:

Guildford Town Centre North Guildford Waverley Surrey Heath

Counselling

Why would the client like to take part in this activity/course?

Current social situation

Does the client currently receive support from other services? Please specify.

Does the client live independently?

Does the client have any issues with drugs or alcohol? If so, please specify

Signed:

Date:

Print name:

Please return this form to:

Client Services Department, Oakleaf Enterprise, 101 Walnut Tree Close, Guildford, Surrey, GU1 4UQ

katiedewick@oakleaf-enterprise.org | Tel: 01483 303649 | Fax: 01483 537069



