 **Walsall Befriending Service Referral Form**

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| This form is to tell us that you are interested in accessing this service.  You will be contacted using the details provided to book an informal chat (by phone or video call) to discuss this with you further. |

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| **Please note** - \* Indicates a mandatory section to complete  All information on this form is kept in line with our data protection policy and is collected for legitimate purposes. Should you wish to view our privacy notice that explains things in more detail, our full privacy statement can be accessed on our website or you can ask us for a copy. Contact us at info@autismwestmidlands.org.uk or phone us on 0121 450 7582  **Once completed**, please return this form to Adult Community Services, Autism West Midlands, Imperial Court, Sovereign Rd, Kings Norton, Birmingham, B303FH or email: [lorene@autismwestmidlands.org.uk](mailto:lorene@autismwestmidlands.org.uk) |

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| **Information** | | | | | | |
| **First Name** |  | **Address** |  | | | |
| **Surname** |  |
| **Contact Number** |  |
| **Email** |  | **Postcode** |  | | | |
| **Date of Birth** |  | **Gender** |  | | | |
| **Ethnic Group** |  | **Contact Preference** | Phone | Email | Text | Post |
| **Autism Diagnosis and Date** |  | **GP Details** |  | | | |

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| **Information On Refer** | | | | | | |
| **Who is completing this form?** | Self | Parent / Carer | Social Care | Health Care | Diagnostic Service | Others |
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| **Name of person referring** |  | | | | **Job Title** |  |

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| **Further information** | | | | | | | | | | |
| **Reason for referral** | Please state below the areas of support that you feel would be helpful for you when accessing the group: | | | | | | | | | |
| **Further information** | Should you have any further information that you wish to share with us please write that here: | | | | | | | | | |
| **Employment/income status:**  **(please tick as many as apply)** | Employed 16hrs + per week | Unemployed and in receipt of ESA | Receiving DLA / PIP | Employed under 16hrs per week | Volunteering | Studying | Unemployed and in receipt of JSA/UC | Accessing a work program | Other (please specify) |

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| **Are you able to travel independently?** |  |

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| **Medical and Health information** | |
| These questions are to determine if we need to make any adjustments in order for you to access our service, or anything we need to be aware of whilst you are with us. Please complete thoroughly as any gaps in information may result in a delay in processing your referral. If required, we may need to contact you to discuss or for further information. | |
| **Medical Conditions / Other Disabilities\***  **Do you have any medical conditions, other disabilities, or serious allergies?**  *If ‘Y’ please provide details such as: How can we help/support you with this? What do we need to do if you have an issue with your medical condition or allergy whilst you are here?* *(E.G. If you require medical equipment, asthma inhaler, insulin dispenser etc. please tell us where you keep this and how to help* |  |
| **Mental Health Conditions\***  **Do you have any mental health conditions we need to be aware of?**  If ‘Y’ please provide details such as: Will this affect your access to our service? Is there anything we can do to support you with this? What are your triggers? What do we need to do if you have an issue with your mental health whilst you are here? (Mental Health conditions could include depression, high anxiety, OCD, phobias) |  |
| **Criminal Record\***  **Do you have a criminal record?**  If ‘Y’ please provide details. *Please note any criminal record you have will be discussed with you and any risk is assessed. It will not automatically exclude you from undertaking any support within our service.* |  |
| **Anything else\***  Is there anything other information you would like us to know? For example, any **sensory differences**, history of vulnerability, or absconding. |  |

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| **Emergency contacts** | **Contact 1\*** | **Contact 2 (if required)** |
| **Name:** |  |  |
| **Relationship to you:** |  |  |
| **Contact details:** |  |  |

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| **Please read before signing - *The information that I have provided is correct to the best of my knowledge. I understand that this information will be used only for the purposes of me accessing this service. I understand that my details will be stored securely and in accordance with the confidentiality and data protection policies of Autism West Midlands.*** | | | |
| **Signature** |  | **Print Name** |  |
| **Relationship to referral?** |  | **Date** |  |