**The referral form is intended for external frontline workers who wish to request a service offered by SOAR for their client. Note: All fields are required unless indicated as optional (\*)**

**This form should be completed and emailed to** [**enquiries@soarcommunity.org.uk**](mailto:enquiries@soarcommunity.org.uk)

**1.Client Contact Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | First |  | |
| Last |  | |
| **Contact** | Home |  | |
| Mobile |  | |
| Email\* |  | |
| **Address** |  | | Postcode: |
| **Date of Birth** |  | | |
| **Registered GP Surgery** |  | | |

**2.Client Area of Support**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Support Areas**  **(tick if applicable)** | **Work, volunteering & learning** |  | | **Healthy Lifestyles** |  | | **Social Networks** | |  |
| **Housing** |  | | **Benefits** |  | | **Debt** | |  |
| **Emotional Wellbeing** |  | | **Families & Parenting** |  | | **Other (please specify)** | |  |
| **Please state reason for referral.**  (please provide as much information as possible, as this will help us decide on the best form of support we can offer) |  | | | | | | | | |
| **Non-English Speaker (tick if applicable)** | | | Yes | | | No | | If yes please state primary language | |
| **Has the client accessed SOAR services before?** | | | Yes | | | No | | Not sure/prefer not to say | |

**3. Referring Organisation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Organisation** | (please state): | | | |
| **Contact** | Name |  | | |
| Role |  | | |
| Tel |  | Email |  |
| **Please contact a member of the referring organisation before contact with client is made.** | | | Tick if applicable. |  |
| **Please confirm that the client has given specific consent (inc verbal) to be referred to the relevant SOAR services and approved referral partners**  **Note: Without patient consent this referral cannot be assessed and will be returned to referring staff.** | | | Tick if applicable. |  |
| **Referral Date**  **(please confirm date of referral)** | | | Date: / / / | |

**4. Client Eligibility Criteria**

|  |  |
| --- | --- |
| **Will See clients who are:**   * Socially isolated * Mild-moderate mental health issues * Long term conditions * Frequent attenders to GP/A&E * Struggling to access /navigate local and city-wide services.   Staff can refer to the following service areas based on client need & wishes:   * Work, Volunteering & Learning * Healthy Lifestyles * Social Networks * Housing * Benefits * Debt * Emotional Wellbeing * Families & Parenting * Other (please state).   *Note:*   * *One or more service support area/s can be selected* | **Won’t See clients:**   * Who are under 18 * Who are experiencing acute episodes of psychosis and not receiving support * With primary issues of drug and alcohol misuse and not receiving support * Who are a threat to themselves or others |