The Old Moat Garden Centre Wellbeing Services Referral Form

For office use only
Date referral received:
Date of first response to referral:

Personal Information

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Dr ☐ Other Gender: ☐ Male ☐ Female ☐ Other

Surname_____ First Names_____ Date of Birth …./…./……

Address_____

Postcode_____ Tel No_____ Email _____

What would you like to achieve? (optional)

What do you feel we need to know about your physical and mental health?

Mental Health (e.g. nature of illness)

Physical (e.g. visual or audio impairment, physical disability, epilepsy, diabetes etc.)

Learning Disability

Drug or Alcohol Dependency

Supporting statement (optional)

Additional information

Professionals Involved

Self Referral Yes/No

Referrer _____ Address _____

_____ Postcode _____ Telephone _____

Is there a current risk assessment available?: Yes No (If yes, please include where appropriate)

Care Co-ordinator_____ Tel No_____

GP _____ Tel No _____

Other _____ Tel No _____

In accordance with the Data Protection Act of 2018, all information provided on the referral form and in any further dealings with The Old Moat Garden Centre will be treated as confidential and will not be disclosed to any third party outside of the Partnership without express consent from the client.

Signed: ……..……... Date: ……..

Signed Referrer (where appropriate): ……. Date: ……..

Please attach any relevant paperwork as appropriate

Please return to:

The Old Moat Garden Centre
Richmond Fellowship
Horton Lane
Epsom
Surrey
KT19 8PQ

Tel: 01372 731971
Email: contact.moat@richmondfellowship.org.uk