

|  |
| --- |
| **APPLICANT DETAILS** |
| **First Name:** | **Surname:** |
| **DOB:** | **Age:** | **Gender** Male/Female |
| **Address:****Post Code:** | **Dependents:**(Children and ages) |
| **Preferred Contact Tel No:** |
| **Email Address:** |  |
| **Nationality:****Preferred Language:****Is an Interpreter required:** Yes / No | **Immigration Status:** UK National / EUNational / Asylum seeker / Student or working Visa / Leave to remain / No Recourse to Public Funds |
| **Hb STATUS** |
| **SUPPORT NEEDS / REASON FOR REFERRAL.**(Indicate if support need is high, medium or low) |
| **Area of Support** | **** | **Area of Support** | **** |
| Welfare / Benefits |  | Emotional Wellbeing |  |
| Housing / Tenancy support |  | Access to cultural or leisure activities  |  |
| Budgeting / Managing Money |  | Managing health (incl. healthy eating, smoking cessation, alcohol awareness) |  |
| Hospital:  |  |  |  |
| Other Please State:  |  |  |  |
| Access to Education or Training |  | Employment Advice |  |
| **Please give any other information that will help us to provide the appropriate support****(including any known health conditions, disabilities, risk of harm to self or others):** |
| **CLIENT CONSENT** |
| **I hereby give my informed consent for referring agency to provide information about me****And I confirm that I wish to receive support as detailed in this referral**Signature of client ………………………………………………………………… Date …………............................... |
| **Referral Agency/Self:** | **Contact Name & Phone:** | **Date of Referral** |
| **Acknowledgement of Referral** | **By:** | **Date** |

**OSCAR ADULT SERVICES REFERAL FORM**

**Organisation for Sickle Cell Anaemia Relief and Thalassaemia Support**

**OSCAR Birmingham, 22 Regent Place, Jewellery Quarter, Birmingham B1 3NJ**

**Tel: 0121 212 9209 Fax: 0121 233 9547 Email: admin@oscarbirmingham.org.uk**