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| REFERRAL TO ADVICE LEWISHAM: From statutory agencies or approved community partners | | | | | | | | |
| REFERRER DETAILS | | | | | | | | |
| Name of referrer: | | | Tel: | | | | | |
| Agency: | | | Date of referral: | | | | | |
| CLIENT’S DETAILS | | | | | | | | |
| Name: | | | DOB: | | | | | |
| Address: | | | Gender: | | | | | |
| Ethnicity: | | | | | |
| Tel:  Email: | | | Client’s NI number: | | | | | |
| GP: | | | | | | | | |
| Is it OK to contact the client at home? Yes No | | | If no please give alternative contact details: | | | | | |
| Does the client have a disability? Yes No | | | Please state here: | | | | | |
| Is a Home Visit Required? Yes No | | |  | | | | | |
| **REASON/S FOR REFERRAL (please tick)** | | | | | | | | |
| Welfare Benefits Check |  | Welfare rights advice | |  | Advocacy/appeals |  | Other |  |
| Form filling |  | General Advice | |  | UC Support |  |  |  |
| Please give details, including any other issues that Advice Lewisham needs to be aware of to support this client.: | | | | | | | | |
| Client Consent  I consent to this referral and to share my personal information with Advice Lewisham detailed on this form  Name ………………………………………. Signature………………………….. Date …………………. | | | | | | | | |
| **RETURN FORM TO** | | | | | | | | |
| **Email:** [referral@advicelewisham.org.uk](mailto:referral@advicelewisham.org.uk) **TEL:** 0800 231 5453  **Post:** REFERRAL, Advice Lewisham,Leemore Centre, 37 Clarendon Road**,** London. SE13 5ES | | | | | | | | |