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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 ConsentI consent to this referral and to share my personal information with Advice Lewisham detailed on this formName ………………………………………. Signature………………………….. Date …………………. |
| **RETURN FORM TO** |
| **Email:** referral@advicelewisham.org.uk **TEL:** 0800 231 5453**Post:** REFERRAL, Advice Lewisham,Leemore Centre, 37 Clarendon Road**,** London. SE13 5ES |