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| Description: Z:\SDAIS ORGANISATION\Leaflets & Publicity\Logos\New Brand 2016\New Brand SDAIS Colour Logo.png | **REFERRAL TO SDAIS** **FAX TO** : (01642) 612666  **E-MAIL TO** : [support@stockton-cab.co.uk](mailto:support@stockton-cab.co.uk) | Description: Z:\SDAIS ORGANISATION\Leaflets & Publicity\Logos\New Brand 2016\New Brand SDAIS Colour Logo.png |

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|  | **Referral from:** | | | | | | | | | | | |
| Name Click here to enter text.  Organisation Click here to enter text.  TEAM: Click here to enter text.  Contact details – Tel Click here to enter text.  Secure Email: Click here to enter text.  Self Referral: □ | | | | | | | | | | Referral Details taken by:  (Name): SWAN - Marie | | |
| Client/Case Details | | | | | | | | | | | | |
| Name of client | | | Click here to enter text. | | | | | | | | Click here to enter text. | |
| Date of referral: | | | Click here to enter a date. | | | | Date of Birth: | | | | Click here to enter text. | |
| Address: | | | Click here to enter text. | | | | | | | | Postcode: (Essential)  Click here to enter text. | |
| Landline  Message OK? | | Click here to enter text.      Yes/noChoose an item. | | | | | | Mobile  Message OK? | Click here to enter text.      Yes/noChoose an item. | | | |
| Email: | | | | Click here to enter text. | | | | | | | | |
| **Health Conditions** | | | | **Respiratory Disease  Cardio-vascular  Disability  Stroke**  **Other (state)** Click here to enter text. | | | | | | | | |
| **NHS No. (if known) …………………………….National Insurance Number (if known)…………………………….** | | | | | | | | | | | | |
| Afternoon Appointment Outreach AppointmentHome Visit EssentialSupport worker need to attend | | | | | | | | | | | | |
| If a home visit is essential, please detail what prevents client from getting into main office  Click here to enter text. | | | | | | | | | | | | |
| Deadlines/Emergencies – Are there any emergencies or deadlines that we need to be aware of. Please detail below:  Click here to enter text. | | | | | | | | | | | | |
| **Reason for referral** | | | | | | | | | | | | |
| Benefit Claim Form  If Yes, has form been ordered? | | | | | Choose an item.  Choose an item. | Advocacy | | | | | | Choose an item. |
| Consumer | | | | | Choose an item. | Benefit check | | | | | | Choose an item. |
| Housing | | | | | Choose an item. | Community care (please provide details below) | | | | | | Choose an item. |
| Debts | | | | | Choose an item. | Employment | | | | | | Choose an item. |
| Budgeting/Financial products | | | | | Choose an item. | Other (please state) Click here to enter text. | | | | | |  |
| Energy Advice | | | | | Choose an item. |  | | | | | |  |

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| Further details of referral (if required or not covered above) |
| Click here to enter text. |
| **Outcome of referral INTERNAL USE ONLY** |
| Date referral received:  Action Taken:  Actioned by:  Date Actioned:  HV/Appt Arranged – Date + Adviser |

**THIS FORM SHOULD BE FILED IN THE SDAIS REFERRALS FILE IN RECEPTION. COPY TO TEAM IF REQUIRED.**

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| Policy: SDAIS Referral Form | Authorised by: IB |
| Version: 2 | Location: Bath Lane |
| Version Date: 3rd February 2017 |  |