

**Referral Form**

By email: sheffield@togetherwomen.org

By post: 106 Arundel Lane, Sheffield, S1 4RF

Tel: 0114 2758282

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| **Contact details** |
| **First Name:**       | **Surname:**       | **Date of Birth:**       |
| **Address:**       |
| **Postcode**:       | **Contact Details:**  |

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| **I want to be referred to the following group programmes/activities:** |
| Women Wellbeing Café | [ ]  | Healthy Relationships | [ ]  |
| Cooking Class | [ ]  | Financial Fitness | [ ]  |

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| **I want support to:** |
| Improve my health | [ ]  | Improve my wellbeing | [ ]  | Improve my personal safety | [ ]  |
| Increase my confidence & self-esteem | [ ]  | Increase my participation in community activities | [ ]  | Better manage my money | [ ]  |
| What support would you like that is not covered above?Would you like to tell us anything else about yourself? |

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| **Dependents** |
| **Full Name** | **Gender** | **Dates of Birth** |
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| **Diversity Details** |
| **I would describe my ethnic origin as:** |
| Asian - Indian  | [ ]  | Asian - Chinese | [ ]  | Gypsy or Irish Traveller | [ ]  |
| Asian - Bangladeshi | [ ]  | Asian – any other background  | [ ]  | Mixed ethnic background | [ ]  |
| African | [ ]  | Any other Black/African/Caribbean | [ ]  | White Irish  | [ ]  |
| Arab | [ ]  | Caribbean | [ ]  | White British  | [ ]  |
| Asian - Pakistani | [ ]  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | Do not wish to answer | [ ]  |
| **I would describe my sexuality as:**  |
| Bisexual [ ]  | Heterosexual [ ]  | Lesbian [ ]  [ ]  | Other | I do not wish to answer [ ]  |
| **I would describe my religion as:**  |
| Name:  | None [ ]  | I do not wish to answer [ ]  |
| **Do you class yourself as having a disability or additional learning needs?** | Yes [ ]  | No [ ]  | I do not wish to answer [ ]  |
| If yes, please give details below:       |
| **Are there any agencies already providing you with support?** |
| **Agency**:  |
| **Worker**:       |
| **Contact details: Phone Email** |
| **Would you consent to us contacting them:** Yes [ ]  No [ ]       |

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| **Information sharing. Are you the referring agency?**  |
| **Is there any risk associated e.g., self-harm/harm to others**  |
|       |

**The information you give on this form will be held in confidence.**

