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| Specialist Practitioner Marginalised Communities  REFERRAL FORM |
| EMAIL FORM TO thgpcg.marginalisedcommunities@nhs.net |
| Referral criteria for specialist support: |
| - Must be a resident in Waltham Forest □ |
| - Young adult up to the age of 19 □ |
| - Adults above the age of 19 must have dependents □ | |
| - Willing to engage with services □ |
| **REASON FOR REFERRAL:**  - Refugee □ - Exploitation □  - Substance Abuse □ - Domestic Violence □  - Displaced Person □ - Travelling Community □  - Unaccompanied Minor □ - No recourse to public funds □ |
| Child’s first name: Parent/ Guardians first name: |
| Surname: Surname: | |
| Phone number: Phone number: | |  |
| Date of Birth: Email: | |
| NHS number: NHS number: | |
| Address: Address: | |
| Ethnicity: Ethnicity: | |
| **CLIENT CONSENT FOR REFERAL:** YES □ NO □ **DOES THE CLIENT REQUIRE AN INTERPRETER:** NO □ YES □: LANGUAGE: |
| School: CHILD PROTECTION:  CHILD IN NEED:  LOOKED AFTER CHILD: □ |
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| Current concerns / Vulnerabilities: | |
| What support has been given so far: | |
| Details of professionals already working with family:   |  | | --- | | Additional information for referral: | | Patient’s general health/ development: |   NAME OF PROFESSIONAL MAKING THE REFERRAL:  ROLE:  ADDRESS:  SIGNATURE:  DATE:  CONTACT NUMBER:  EMAIL: |