Client Authorisation for Referral

Client details

Title: First Name:

Surname:

Address:

Postcode:

Tel No.

Email:

Date of Birth:

Now please continue overleaf...

Referring Agency

☐ **Self** ☐ **GP Surgery**

☐ **Church** ☐ **Other**

Please tick as appropriate

Name of referrer (inc agency):

Tel No.

Email:

Additional Comments (inc risks)

Now please continue overleaf...

Client Authorisation for Referral

Client details

I give my permission for my contact details to be passed to the 'Hope in the Community Bournemouth' - and I understand that all information will be held in accordance with the Data Protection Act.

Client Name:

Client Signature:

Date:

Referrer Name:

Referrer Signature:

Date:
(Referrer to tick if given)

☐ **Verbal Consent** (Referrer to tick if given)

Then we'll take it from here..

Take this page to HitC at our address:

HitC, 120 Southbourne Road, Bournemouth, BH6 3QJ

Call our office on 01202 419506
or Tess our Coordinator on 07752 597334

Email: hitcbournemouth@btinternet.com

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