

SAHELIYA REFERRAL FORM



OFFICE USE ONLY

Date Referral Received:
 Received By(Full Name):
 Client ID:

Name:	Have you accessed Saheliya services before? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address:	
Postcode:	
Phone:	Age:
Mobile:	DOB:
Email:	
Preferred method of contact: Phone <input type="checkbox"/> Message <input type="checkbox"/> Post <input type="checkbox"/> Email <input type="checkbox"/>	

Additional Information		
Nationality:	Ethnicity:	Religion:
Languages Spoken:		
Language Support Required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Availability:				Notes:	Child's Full Name:	M/F	DOB:	Crèche Required
MON	am	<input type="checkbox"/>	pm	<input type="checkbox"/>				<input type="checkbox"/>
TUES	am	<input type="checkbox"/>	pm	<input type="checkbox"/>				<input type="checkbox"/>
WED	am	<input type="checkbox"/>	pm	<input type="checkbox"/>				<input type="checkbox"/>
THURS	am	<input type="checkbox"/>	pm	<input type="checkbox"/>				<input type="checkbox"/>
FRI	am	<input type="checkbox"/>	pm	<input type="checkbox"/>				<input type="checkbox"/>

Service Request:			
Group Work <input type="checkbox"/>	Counselling <input type="checkbox"/>	Comp. Therapies <input type="checkbox"/>	Learning Hub <input type="checkbox"/>
1:1 Support (Please specify below) <input type="checkbox"/>			
Housing Advice <input type="checkbox"/>	Legal Advice <input type="checkbox"/>	Support Accessing Health Services <input type="checkbox"/>	
Young Saheliya -12-25			
Counselling <input type="checkbox"/>	1:1 Support <input type="checkbox"/>	Group Work <input type="checkbox"/>	Family Support <input type="checkbox"/>

Referral Made By:Self Referral Third Party Referral

Relationship:

Name and Address (for third party referrals only):

Phone:

Reason for Referral:

Crisis Referral Yes No If Yes, please specify:

Date of Referral:

Other agencies/ schools involved: (eg Shakti, Social Work, Shelter etc)

Agency:

Key Worker:

Number:

Agency:

Key Worker:

Number:

In case of emergency, please contact:

Name:

Relationship:

Phone:

Medical Centre

Phone:

Address:

Disabilities:

Medical Needs:

Anything else you would like us to know:**Please return form to:**

Saheliya, 125 McDonald Road, Edinburgh, EH7 4NW

Email:

info@saheliya.co.uk

Phone:

0131 556 9302

Saheliya is committed to meeting its obligations under the Data Protection Act (1998). Saheliya will hold and process relevant information in order to provide the services that you require. It is the policy of Saheliya to ensure that all data provided by you or the person referring you to the service will be stored securely and checked for accuracy and authenticity as the opportunity arises.

You have the right to access the personal information that Saheliya stores on you, subject to other legal restrictions and third party confidentiality. If you wish to see these details please ask the Manager or Coordinator of the service who will provide you with access to information specific to you. Should you have a complaint regarding the processing of your personal data you should write to the Data Controller, Saheliya, 125 McDonald Road, Edinburgh, EH7 4NW. By consenting to being referred to a Saheliya service and having read the statement above, you are providing your consent for that data to be held and processed.

Further details regarding our privacy policy can be viewed at the following address.

www.saheliya.co.uk/saheliya/downloads