REVOLUTION
At Renaissance UK

HIV Support Referral Form

Referral Service:	
Name of person referring:	
Email of person referring:	
Date of referral:	
Contact number:	
Confidentiality and information sharing discussion explained?	Yes ☐ No ☐

Client Details			
Surname:		Forename:	
Date of Birth:		Age:	
Gender Identity (Please Tick): Which of the following options best describes how you think of yourself?		Woman (including trans woman)	☐
		Man (including trans man)	☐
		Non-Binary	☐
		In Another Way	☐
		Not Stated (declined to provide a response)	☐
		Not Known (not recorded)	☐
Trans Status (Please Tick): Is your gender identity the same as you were given at birth?		Yes	☐
		No	☐
		Not Stated (declined to provide a response)	☐
		Not Known (not recorded)	☐
Address:			
Postcode:		Contact Number:	
Email:			
We require 2 methods of contact. Please **delete** any methods of contact that the client **does not** agree to.		Letter to home address	Yes
		Phone call	Yes
		Voicemail left	Yes
		Text message	Yes
		Email	Yes

GP Name:	
GP Address:	
GP Postcode:	
GP Phone Number:	

Please state the primary reason for contacting the service below: (Overview of what help the individual is looking for and what they hope to gain from service support)

Priority Risk Checklist	**Tick**	**Please expand on any risk identified:**
Pregnant	☐	
Safeguarding Concerns	☐	
Domestic Violence	☐	
Substance Misuse	☐	
Mental Health Condition/Symptoms	☐	
Physical Health Condition/Symptoms	☐	
Risk of Self-Harm or Suicidal Thoughts	☐	
Threat to Others	☐	
Offending Behaviour	☐	
Learning Difficulties	☐	
Other: Please State	☐	

Consent statement (to be signed by individual)

I understand that these details will be passed on to Renaissance UK for a more detailed assessment to be offered. I am aware that I have requested this referral to be made. Anonymous details will be used to monitor service levels and quality.

Client Signature:

Referrers Signature:

Date:

Send this completed form to the case working team at HIVRef@Ren-uk.com