

Referral Service:	
Name of person referring:	
Email of person referring:	
Date of referral:	
Contact number:	
Confidentiality and information sharing discussion explained?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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:	
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Postcode:	Contact Number:
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Email:

We require 2 methods of contact. Please delete any methods of contact that the client does not agree to.	Letter to home address
	Phone call
	Voicemail left
	Text message
	Email

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)

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

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

