**Shoreditch Trust Referral form**

You can refer yourself or ask a professional/carer to refer you.   
We help people to:

* Recover from a Stroke
* Feel motivated to manage a long-term health condition such as diabetes, hypertension, or other physical health conditions affecting quality of life
* Make lifestyle changes like getting active, eating well & dealing with stress
* Find help for a mental health condition
* Find support in pregnancy or with a young family
* Join a local walk or a Community Table lunch

*We help people individually and in groups.*  
  
*To find out more and see our current schedule of activities, please visit our website:*   
[*https://www.shoreditchtrust.org.uk/*](https://www.shoreditchtrust.org.uk/)

*If you have questions, please just get in touch on 02070338500 or* [*referrals@shoreditchtrust.org.uk*](mailto:referrals@shoreditchtrust.org.uk) *Shoreditch Trust, 8 Orsman Road, N1 5QJ*  
  
*To find out more about local service and support, please refer to the Find Support Services map for information:* [*https://find-support-services.hackney.gov.uk/*](https://find-support-services.hackney.gov.uk/)

*We observe strict rules and regulations about handling people's data. You can find out more about this by visiting our website* [*https://www.shoreditchtrust.org.uk/policies/*](https://www.shoreditchtrust.org.uk/policies/)

|  |  |
| --- | --- |
| *Date of referral* |  |
| *If you are completing this form on behalf of somebody else, please confirm Your Name, Your Role, Contact Number, Email* |  |

***Essential information*** *(this is the minimal information we need to be able to accept a referral)*

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |
| Date of Birth: |  | Contact Number(s): |  |
| Address: |  | E-mail (if available): |  |
| Postcode: |  | Ethnicity (please select): | * Asian/ Asian British * Black/ African/ Caribbean/ Black British * Mixed/ Multiple Ethnic Group * Other Ethnic Group * White * Prefer not to say * Unkown |
| Sex (please select): | * Male * Female * Prefer Not to say * Self-described or use my own term |  |  |
| *Please confirm that the person has consented to this referral? (you must ensure you have their consent before referring)* | | * Yes * No | |
| Reason for referral/ changes they wish to achieve: | |  | |
| GP Surgery: *(this information is used to be able to connect with relevant support)* | |  | |
| Are you aware of any **risks**, for example about your/ the person’s safety or the safety of others? | | * + Yes (please give details) * No/ Unknown | |

|  |  |
| --- | --- |
| Additional info(not essential but helpful if you can provide us with this - for example: other support in place; health conditions; access or language needs; any care package in place; lives alone; contact details for next of kin where appropriate) |  |
| Where did you hear about Shoreditch Trust? |  |

Complete and return this form to

[referrals@shoreditchtrust.org.uk](mailto:referrals@shoreditchtrust.org.uk) or [*connect@shoreditchtrust.org.uk*](mailto:connect@shoreditchtrust.org.uk)

To discuss making a referral or to refer over the phone, please call us on: 02070338500

Shoreditch Trust, 12 Orsman Road, London, N1 5QJ

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