VECC Referral Form

Name and Organisation of Referrer:	Address of Referrer:
Tel No:	**Email:**
Date of referral:	**Is this individual aware of this referral:** Yes ☐ No ☐

Nature of Disability / Work Limiting Health Condition:

Physical disability ☐   Substance/Alcohol misuse ☐   Mental Health ☐

Learning disability ☐   Sensory Impairment ☐   Other ☐

Please provide brief details:

Please ensure that a Professional assessment {if applicable} and any other relevant paperwork is attached with the referral form:

Reports enclosed:

Professional Assessment: **Risk Assessment:**

Yes   **No**   **Yes**   **No**
☐   ☐   ☐   ☐

Other information:

Other Agencies working with the Individual

Agency	Name	Contact Details	No. of days per week	No. of hours per week

Referral Information

Surname:	First Name (s):
D.O.B:	Email Address:
Full address:	Home Tel No: Mobile No:
Home Circumstances: Live with parents / carer ☐ Live independently ☐	Live with spouse / partner/relative ☐ Live in supported accommodation ☐
What Goal(s) is the individual aiming to achieve? Employment ☐ Volunteering ☐ Connection to group or activity ☐	What specific support will the individual require to achieve this?
Current situation, e.g. clubs, college, social setting	Current day service provision.
What benefits are the individual receiving? Jobs Seekers Allowance (JSA) ☐ Employment Support Allowance (ESA) ☐ Housing Benefit ☐	Tax Credits ☐ Universal Credit ☐ Other ☐ Please specify:
Other relevant contact details: Name:	Relationship
Address:	Contact No: Email:

Medical Information

Medical Conditions:	Medication:
Dietary Requirements:	Allergies: