**Joining the Dots – Referral Form**

Support and information to help improve health and wellbeing for people **aged 18+**

who have or have had a cancer diagnosis, their family, friends and carers.

Please email/scan completed form to: [cddft.joiningthedots@nhs.net](mailto:cddft.joiningthedots@nhs.net) or call **0800 8766887** for assistance.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Referrer Details: (a member of the Joining the Dots team may contact you for more information)** | | | | | | | | | |
| Name: |  | | Tel No: | | | |  | | |
| Job Title: |  | | Mobile: | | | |  | | |
| Organisation: |  | | Email: | | | |  | | |
| Address: | | | | | | | | | |
| I confirm the client has provided consent for this referral and understands the main reason for referral: Yes  No  I confirm that the client has provided consent for Joining the Dots staff to contact the referrer regarding their engagement with the service: Yes  No  Date: | | | | | | | | | |
| **2. Persons Details:** | | | | | | | | | |
| Surname: |  | | | First Name (s): | | | | |  |
| Address: | | | | NHS number (if known): | | | | |  |
| DoB: | | | | |  |
| Gender: | | | | |  |
| Post Code: |  | | | Home No: | | | | |  |
| Email: |  | | | Mobile No: | | | | |  |
| Preferred method of contact: Phone  Mobile  Email  Post | | | | | | | | | |
| Best time to contact client: Day: Time: | | | | | | | | | |
| Consent given to leave message on preferred number? Yes  No | | | | | | | | | |
| Ethnicity (Please state) | | | | | Religion (Please state) | | | | |
| **3. Reason for Referral:** | | | | | | | | | |
| I have/ had a diagnosis of cancer  I am a family member, friend or carer of someone who has/ had cancer  **Please state reason for referral:**  **Please list any other long term health conditions?**  If ‘Yes’ please provide details e.g. diagnosis and effect on day to day life | | | | | | | | | |
| **Please list any current or past cancer treatments?** | | | | | | | | | |
| **Please list any other professionals involved?** | | | | | | | | | |
| **Are there any known risks that the service should be aware of?** Yes  No  If ‘Yes’ please provide details | | | | | | | | | |
| **Additional needs e.g. Audio / Visual Impairment / Literacy / Learning / Physical Disability:** | | | | | | | | | |
| **4. G.P.:** | | | | | | | | | |
| GP Name: | |  | | | | Tel No: | |  | |
| Practice name & address: | |  | | | | | | | |
| **For professional use only: Is there an DS1500/SR1 in place? Yes ☐ No ☐** | | | | | | | | | |

\*\* The data you have provided will be entered into a database and will be securely stored in accordance with the Data Protection Act 1998/GDPR 2018 and our Policies and Procedures.