

Referral Form for **CONNECT** course

To be completed by or with the person wishing to attend the **CONNECT** course

Surname	Forename	Date of Birth
Present Address		
Telephone		
Who is currently supporting you e.g. family, friends or professional support (GP etc)?		
Emergency contact		
Name		
Address, if different from above		
Telephone		
Relationship to you		
What are your reasons for wanting to take part in the CONNECT course?		
Is there anything you wish to tell us about yourself which could affect your attendance or participation on the course - e.g medication can make you sleepy, difficulty in concentration		
What would you like us to do if any difficulties arise?		

Details of Supporting Agency

Name:

Address

.....

.....

Telephone Number

Note to Supporting Agency

Can you give a commitment to continue to support this person throughout the Connect course?

Yes

No

Applicant

Supporting Agency

Signature

Signature.....

Print Name.....

Print Name.....

Date

Date