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| **Beacon Service - Referral Form****Please return the completed form to:** **buccg.beaconservice@nhs.net**Incomplete forms may be returned**Any enquiries, please call: 0161 518 5550** **NB: All referrals must be registered with a Bury GP Practice and age 18+** |
| **Name**: |
| **Date of Birth**: |
| **Gender:** [ ]  Male [ ]  Female [ ]  Other [ ]  Prefer Not to Say [ ]  Transgender [ ]  Non-binary  |
| **E-mail Address if known**: |
| **Telephone No**: |
| **Address (please include postcode)**: |
| **Registered Bury GP Practice (please include GP Name)**: |
| **Confirmation of Consent:** *“In line with General Data Protection Regulation legislation (2018), I confirm that by making this referral for the above named individual, I have gained the appropriate informed consent of the individual named”* | **Please Confirm****YES / NO** |
| **Contact Details of Referrer (please include your name, organisation & telephone number)**: |
| **Select from the below the reasons for this referral**: [ ]  Help with Basic Daily Needs [ ]  Low Self-esteem/Confidence [ ]  Motivation for Learning[ ]  Personal Development [ ]  Physical Inactivity [ ]  Socially Isolated [ ]  Mental Health + Wellbeing**Please comment below for any additional information relating to the referral:** |
| **Do we need to be aware of any risks associated when working with the individual? i.e. Pets / Safeguarding / Lone Working etc.?** |