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| **Beacon Service - Referral Form**  **Please return the completed form to:** [**buccg.beaconservice@nhs.net**](mailto: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.?** | |