COMMUNITY REFERRAL FORM

Name of referrer: _____

Name _____

Address _____

Phone _____

Contact Details of referrer including telephone and email _____

Emergency contact _____ Phone _____

Email _____

**Please answer the questions below.

How did you learn about us? _____

Do you have consent to complete this referral form? ☐ Yes ☐ No

Are you on any medication? ☐ Yes ☐ No If yes, which ones _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week ? ____ How many hours? ____

**Please mark the area of interest, specific to your needs

- ☐ Learning Disabilities
- ☐ ASD
- ☐ ADHD
- ☐ Mental Health Challenges
- ☐ Older People Aged 65+
- ☐ NEET/at risk Young People
- ☐ Emotional/Social challenges
- ☐ Grief/Bereavement
- ☐ SEND (Children + Young People)
- ☐ Long term health condition
- ☐ Please specify:
- ☐ If Others, please specify:

Please use this box to outline the reasons for your referral, including any information that would be helpful to know to refer into the correct service i.e. support needs, communication needs, health conditions, allergies, etc

I understand that by completing this form I am consenting for my information to be shared, or to be shared on behalf of the person I am referring. I agree to be contacted by Dennis and Dyer Boxing Academy in relation to this referral and my personal information will not be shared or used for any purposes outside of the scope of this referral.

Signature _____ Date _____