******Gambling Service Referral Form**

Referrals can be made by telephone on **0191 5623309** or by completing the referral form and sending it via secure email to Gambling.Referrals@neca.cjsm.net

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| **Client Details** |
| Name: | Click here to enter text. |
| Address: | Click here to enter text. |
| Home Phone: | Click here to enter text. | Mobile Phone: | Click here to enter text. |
| Email: | Click here to enter text. |
| Date of birth: | Click here to enter text. |
| **Consent to contact** (Tick all that apply) |
| Letter |[ ]  Availability:Click here to enter text. |
| Home phone  |[ ]   |
| Home phone voicemail |[ ]   |
| Mobile |[ ]   |
| Mobile voicemail |[ ]   |
| Text |[ ]   |
| Email |[ ]   |
| Consent to contact referral agency |[ ]   |
| **Presenting Issues** |
| Problem Gambler |[ ]  Any identified risks/ concerns:Click here to enter text. |
| Person at risk of a gambling problem |[ ]   |
| Partner |[ ]   |
| Family Member/ Friend |[ ]   |
| Previously accessed services by GamCare/GamCare Partner Agency | Yes |[ ]  No |[ ]  Prefer not to say |[ ]
| **Referrer Details** |
| Name: | Click here to enter text. | Referral Date: | Click here to enter text. |
| Organisation: | Click here to enter text. |
| Address: | Click here to enter text. |
| Contact number: | Click here to enter text. |
| Email: | Click here to enter text. |
| Client consent to share basic information with the referrer i.e., date of appointment and attendance: | Yes |[ ]  No |[ ]   |