STARS Online Referral Form

Clients Details (to complete if you are self-referring)

Client Name:

D.O.B.

Home Phone No: (Are we OK to contact on this number? Yes ☐ No ☐)

Mobile Phone No: (Are we OK to contact on this number? Yes ☐ No ☐)

Address:

(Are we OK to send info to this address? Yes ☐ No ☐)

Other contact Information:

GP (NHS No.):

Substance use (Current frequency & Amount):

Physical/ mental health issues:

Pregnant: Yes ☐ No ☐

Reason for referral:

Previous access to services:

Client aware of referral? Yes ☐ No ☐

Referrers Details (to complete if referring for someone else)

Referrer Name: _____ Date: _____

Organisation: _____ Phone No: _____

E-Mail Address: _____

ONCE COMPLETED PLEASE RETURN TO

humankind.starseast@nhs.net