



## Kushinga Project

### Self Referral Form

#### Referral Guidelines

##### **WHO CAN ACCESS THE SERVICE?**

The Kushinga project is available to African people in Birmingham who provide informal care services.

The service is open to:

- (i) Adults Carers of an adult or child(ren).
- (ii) People who have recourse to public funds.

##### **WHO CAN REFER?**

Clients can self-refer. It is preferable that a relevant health/social care professional completes this Referral form with the consent of the Client. All applications to this service will be treated in confidence.

##### **AFTER THE REFERRAL**

On receipt of this application, the Client will be contacted and a needs assessment will be completed.

Please complete and return application form. This application form will be treated in confidential and sensitive manner in accordance with ACCR's strict policies and procedures on confidentiality



## ***Kushinga Project Referral***

<b>1</b>	<b><i>Personal Details</i></b>
Title:      Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other: _____	
First Name(s):	Surname:
Address:          Postcode:	Date of Birth:
	Age at time of referral:
	Tel:
	Email:
Country of Origin:	
Right to remain in the UK:      Yes <input type="checkbox"/> No <input type="checkbox"/>	
Main Language:	English Speaking?   Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Has the client given their consent for this referral to be made and their details given?</b> Yes <input type="checkbox"/> (Please do not make a referral until the client has given their consent)	
<b>Does the client have recourse to public funds?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	



**4****Other services being accessed**

Please tell us about any other services you are currently accessing?

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If other professionals are involved, please provide their details (if relevant):

Title:      Mr    Mrs    Ms    Miss    Dr    Other: \_\_\_\_\_

First Name(s):

Surname:

Position:

Organisation:

Address:

Tel:

Fax:

Email:

Postcode:

**Declaration**

I confirm that the information provided in this referral is true to the best of my knowledge

Signature of referrer: \_\_\_\_\_      Date: \_\_\_\_\_

Please return this form by post or by fax:

Post: ACCR, Prospect Hall, 12 College Walk, Selly Oak, Birmingham, B29 6LE

Fax: 0121 415 6699