ocd action
it's time to act

Advocacy for OCD Service

Referral Form

This Section for Office Use Only

Date Received ____

Referrals can be made by phone, email or post. This form will be kept confidential. It is to be used for initiating advocacy involvement.

Please forward this form or telephone through the details to:
OCD Action, Davina House, Suite 506-507, 137-149 Goswell Road, London EC1V 7ET
Tel: 020 7253 5272

If you are referring yourself, please fill in the following. You are not required to complete every box should you choose not to. We may use some information you provide for monitoring purposes, to support us with future funding applications, to provide evidence of the work we've done and to ensure that we are reaching a wide range of individuals. Please note that all personal details will be kept confidential.

Date of referral: .... **Is this a first referral?** YES/NO

Full name: ....

Title: Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Other ☐ please specify: ....

Gender: Male ☐ Female ☐
(please tick)

Current Address, Telephone Number, Email address:

………

………

Age group: **10-19** ☐ **20-24** ☐ **25-34** ☐ **35-54** ☐ **65 -74** ☐ **Over 75** ☐
(please tick)

Ethnicity (please tick):

White British	☐	Asian or Asian British Indian	☐
White Irish	☐	Asian or Asian British Pakistani	☐
White Other	☐	Asian or Asian British Bangladeshi	☐
		Asian or Asian British Other	☐
		Chinese	☐
Black or Black British Caribbean	☐	Mixed White & Black Caribbean	☐
Black or Black British African	☐	Mixed White & Black African	☐
Black or Black British Other	☐	Mixed White & Asian	☐
		Mixed Other	☐

Other ethnic category
(Please specify) ☐ ....

Sexual Orientation (please tick)**:**

Heterosexual ☐

Homosexual ☐

Bisexual ☐

Prefer not to say ☐

Do you have any communication needs the advocate needs to be aware of?

YES ☐ (please specify) ....

NO ☐

Additional Disability (if any) ....

How did you hear about OCD Action's Advocacy Service?

....

Brief details of why you would like advocacy involvement:

Important dates/meetings you would like the advocacy service to be aware of.

Any other relevant information:

If you are filling this form in on behalf of someone else please provide your details here:

Date of Referral: ………………………………………………………………

Name of Referrer: ………………………………………………………………

Relationship to person referring: ………………………………………………………

Organisation (if applicable): ……………………………………………………………

Contact Telephone Number: ……………………………………………………

Email: ………………………………………………………………………

Address: ……

………

………

Has the client given permission for this referral to be made: Yes ☐ No ☐

Please note that we are only able to work with clients who wish to use the advocacy service and we are therefore unable to contact someone who has not given their permission for the referral.