# Freedom CMA Referral Form

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| --- | --- |
| Referrer’s Name |  |
| Referring Agency Organisation |  |
| Referrer’s Contact details |  |

|  |  |
| --- | --- |
| Client(s) Name |  |
| Client’s Address |  |
| Client’s Contact number |  |
| Client’s Email (if available) |  |
| Any additional information  (e.g. needs an interpreter, mobility/access issues, availability for appointments, areas of need) |  |

☐ I hereby authorise you to divulge my contact details and other listed personal

data to Freedom CMA in order to be able to make an effective referral

☐ I authorise Freedom CMA to make contact with me on the details listed above

☐ I authorise the referring agency to share special category data (e.g. health, ethnic origin, criminal record) with Freedom CMA

☐ I authorise Freedom CMA to keep a record of the referral made.

Signed ……………………………………………………………………….

Client name ………………………………………………………………….

Date ………………………………