



## Helping Angels Charitable Association COVID-19 Support Referral Form

Please complete this form and return to: [support@helpingangelsca.org.uk](mailto:support@helpingangelsca.org.uk)

### Section 1 – Personal Information

Name of individual being referred: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email address: \_\_\_\_\_

### Section 2 – Medical History

Please give a brief summary of the individual's medical history and diagnosis of current medical conditions:

### Section 3 – Support Requirements

Please give details of any support currently received (e.g care agency, family member etc):

What areas of support are required? (feel free to tick multiple boxes)

Group support

Weekly Welfare call

Digital/tech support

Shopping

Prescription collection

One hour personal support

Any other areas of support required that are not stated:

### Section 4 – Contact Information & Consent

Name of person making referral: \_\_\_\_\_

Relationship to individual: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Does the individual consent to this referral: Yes  No  (tick as appropriate)

(If no then parent/guardian approval is required in order for the support request to be processed)

I accept that the data provided on this form will be processed and stored for the purpose of Helping Angels Charitable Association and will not be shared with any other parties without my consent. I consent to being contacted by representatives of Helping Angels via email, telephone and post.  (tick to confirm)