

# Referral Form section 2 -

(confidential)

To be completed by Referrer if a health/ care worker e.g. G.P or Social Worker

Specific details of client's condition:

Client's physical health: (e.g. physical disability, asthma, heart condition etc.)

Client's medication and frequency of dose:

How the medication affects the client:

Any other therapies being undertaken by the client:

Any other relevant information which may help the Lighthouse Foundation:

Signature of Referrer: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Referrer: \_\_\_\_\_

Do you wish to partake in the 6 month review yes/no (Delete as appropriate)