Weymouth Community Volunteers

Referral Form

Referral Details

Referral from:	Telephone:
Referred by:	Date:

Client Details

Name: Mr/Mrs/Miss/Ms	D.O.B. / /	Age:
Address:		
Telephone No:	N.I. No: / / / /	

Please circle as appropriate

Employed more than 16 hours a week		Recently completed a custodial sentence or supervision order		Risk Associated	
Yes	No	Yes	No	Yes*	No

Single Parent		Homeless		English first language		Misuse Drugs and/or Alcohol		Health Problems or Disability	
Yes	No	Yes	No	Yes	No	Yes	No	Yes**	No

* Please attach a current risk screen.

** Please supply any details which you feel would assist us overleaf

Why are you referring this person to WCV?

Other information that may assist us.

For office use only:

Gen	Age	Eth	Dis	Interview date	Interview ID	Refs	Placed	Start Date	Data input

Please return to:

Weymouth Community Volunteers
17a Cambridge Road Weymouth DT4 9TJ
Tel: 01305 830255
Fax: 01305 782217