**GamCare Treatment Referral Form**

Please send referrals to: teamleaders@gamcare.org.uk

*Please email referral form password protected, password should be sent in separate email*

|  |  |
| --- | --- |
| **Date of Referral** |  |

**Referrer Details:**

|  |  |
| --- | --- |
| **Organisation Name** |  |
| **Name of Referrer** |  |
| **Contact Details for Referrer** |  |

**Client Details:**

|  |  |
| --- | --- |
| **Name** |  |
| **Phone Number** |  |
| **Email** |  |
| **DOB** |  |
| **Address** |  |
| **Consent to contact** | **Phone** **Voicemail****Email** |

Is the client aware of the referral Yes No

Is the client deemed high risk Yes No

If yes please provide a summary:

Other professionals involved:

Please provide a brief summary of the clients gambling: