

AGENCY REFERRAL FORM

Client name:			
Client address			
Postcode			
Client telephone number			
Client email			
Client date of birth			
Your name			
Your organisation			
If you are referring from a GP Surgery or Health Venue please specify			
Your email address			
Your telephone number			
Reason for referral			
Area of law	<input type="checkbox"/> Debt	<input type="checkbox"/> Housing	<input type="checkbox"/> Benefits
	<input type="checkbox"/> Immigration		
Does the client have any access or language needs? If so please give details			
Are there any deadlines?			
Consent to be signed by client:			
<p>I consent to the information contained in this form being sent to Community Law Service (Northampton and County) and for them to record and keep this information either in paper or electronic format, in accordance with the GDPR (EU) 2016/679. I understand that my details will not be passed to any third party without my further express consent.</p>			
Name:		Date:.....	
Signature:			

Please post this form to the address above, fax to (01604) 232412 or email enquiries@communitylawservice.org.uk. We aim to contact all clients within 3-5 working days of receiving this form. We will attempt contact 3 times, if we are unsuccessful we will write to the client advising of how they can contact us should they still require assistance.