



INTEGRATED
SUPPORT

REFERRAL ENQUIRY FORM

Name of referrer:	Date / time:
Position:	Purchasing authority:
Address:	E-mail:
Telephone number:	Name / initial of service user:
Current residence of SU:	Sex: Male / Female

1. Diagnosis of Service User:

- | | |
|--|--|
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Challenging behaviour |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Autism / Aspergers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prader-Willi Syndrome |
| <input type="checkbox"/> Other.....details: | |

2. Can you please fax or e-mail a profile / background information on the Service User?
YES / NO

3. Where did you hear of Integrated Support?

- Brochure Web site other – please specify:

4. Would you like a copy of our brochure? Yes / No

Buttercrambe Office

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Stanley Office

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