**Pharmacy Referral Form**

**Please Fax this form (on a secure fax to) Ageing Better in Camden: 02072781904**

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| \*Name: | \*DoB |
| Address: | Ethnicity |
| \*Telephone: | Sexuality: |
| Email: | Gender: |
| Religion: | Camden Resident (tick) |
| Lives alone: | Over 60 (tick) |

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| \*I would like support to meet new people and/or to go out more. Or just to find out more about the project. Please pass my details to Community Connectors |  |
| Not counting the people you live with, how often do you meet up with children, family and friends? |  |

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| \*Visited by: | \*From: |
| \*Date: | \*Telephone: |
| *\*IMPORTANT: This must be read to the client: “In signing this form you are consenting to this information being shared with the partner organisations in accordance with the data protection Act 1988” This data will be held on Ageing Better in Camden’s secure database.* | |
| \*Signed: (Client or representative) | |