FACT Services Signposting Form

Client Details				
Name				
Address				
Post Code				
Contact Phone Nos	**Mobile**		**Home**	
Email address				
DOB				

Emergency Contact Name	**Emergency Contact Number**
GP Practice Name	**GP Practice Telephone Number**
Consultant	**Cancer Nurse Specialist**
Medication Information / Allergies etc	
If counselling is required, did any of the above signpost you to FACT or suggest counselling ?	

Diagnosis	
Referred by	
Reason for contacting us	
What would you like help with	

Other information - you may wish to tell us about your family situation etc so that we can support you as much as possible	
Reason for further contact	
Help/advice given by FACT	
Other issues	
Spoken to by (FACT employee)	
Date	

Your Information and Consents

We collect personal information when you register with as either a service user or volunteer. We will use this information to provide the services requested, maintain contact records and, if you agree, to send you information about FACT's services and events. FACT will not share your information with any third party for any purpose. For further information on how your information is used, how we maintain the security of your information, and your rights to access information we hold on you please contact us.

If you would like us to send you information about our events and services please indicate your preferred method below: (please tick the relevant boxes).

Post		Email		Phone	

Please tick here if you are happy for any photographs taken at events which may have you in them to be used for FACT publicity.	

Signature	
Date	

Counselling Referrals – to be sent to Shirley Sheen for action
Services Referrals – to be sent to Services Team for action