|  |  |
| --- | --- |
| Referral Form | Vivup - Hyped Marketing |

# Instructions

Please complete all the fields in pen below and carefully read the statement below regarding explicit consent for TERC to process the personal data provided in this form. Please ensure you refer Clients in all cases to our Privacy Policy at <https://vivup.tercltd.co.uk/UK/PrivacyPolicy.awp> for further information on how we process their data. Please email to eapreferrals@tercltd.co.uk

# Client Details

|  |  |  |  |
| --- | --- | --- | --- |
| Client Full Name: |  | Reference Number  *(Internal Use Only)* |  |
| \*Date of Birth: |  |  |  |

\* This information is only required for an additional cross check when we enter your data into our system

in the event that we have a client with the same name.

# Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| Home Telephone Number: | |  | |
| Work Telephone Number:  (Please provide full number including any area code and extension) | |  | |
| Mobile Number: |  | | |
| Can we send SMS text messages to the above number?  Any Special Contact Instructions: | | Yes: | ¨ |
|  | | 0No: | ¨ |
| (please tick accordingly) | |
| E-Mail Address: | Dreymarie@yahoo.com | | |
| Can we send E-Mail to the above address?  Any Special Contact Instructions? | | Yes: | ¨ |
|  | | 0No: | ¨ |
| (please tick accordingly) | |

Please detail ANY special CONTACT instructions about messages or confidentiality that the Counsellor needs

to be aware of when they need to contact the client.

# Employer Details

|  |  |  |  |
| --- | --- | --- | --- |
| Referred By: |  | Company: | Milton Keynes Hospital NHS Foundation Trust |
| Job Title: |  |  |  |

# Consent

|  |  |  |
| --- | --- | --- |
| \*Has the client provided explicit consent? | Yes: | ¨ |
| 0No: | ¨ |
| (please tick accordingly) | |

IMPORTANT! Please be aware that we are required BY LAW to have obtained EXPLICIT consent from the above individual

and have verifiable evidence of that in the event of a compliance audit by ourselves or the Regulator.

If you do NOT have this, you CANNOT process the personal data of this data subject or complete this referral form.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  | |  | Name |  |
|  | Signature of the Person Submitting this Form | |  |  | Name of the Person Submitting this Form (print) |
| Date of Signature: |  |