|  |  |
| --- | --- |
| **Client/patient contact name**  |  |
| **Client Address** |  |
| **Client contact phone number**  |  |
| **Client relationship to child (if relevant)** |  |
| **Housing tenure****(Owner Occupier/ Social landlord / Private landlord/ other)** |  |
| **If applicable, details of landlord including contact details**  |  |
| **Is the issue mould, damp or both?** |  |
| **When was the issue(s) first noticed?** |  |
| **Have there been previous attempts to remedy the issue(s) and if so, please give details**  |  |
| **Name, role and contact details of the person making the referral**  |  |

|  |
| --- |
| **Client Consent** |
| I understand that my personal information will be shared with the below organisations where it is both necessary and appropriate to do so.* Trafford Care & Repair
* Trafford Council Departments
* Other Local Authorities
* Other Housing Providers (i.e. your social housing landlord)
* Your Private Landlord / Managing Agent (where applicable)
 |
| Has the patient consentED for this referral to be made on their behalf?(please PLACE X NEXT TO or underline RESPONSE) | YES | NO |

**Send completed form to****housing.strategy@trafford.gov.uk** **via NHS.net or using encryption.**