|  |  |
| --- | --- |
| **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**](mailto:housing.strategy@trafford.gov.uk) **via NHS.net or using encryption.**