**CLIENT REFERRAL FORM TO GAMCARE**

**I agree to a referral being made to GamCare:**

|  |  |
| --- | --- |
| Name |  |
| DOB |  |

|  |  |
| --- | --- |
| Postcode |  |
| Address |  |

|  |  |  |
| --- | --- | --- |
|  |  | Consent to Contact  |
| Telephone Number |  | \*Please Select\* |
| Voicemail |  | \*Please Select\* |
| Text |  | \*Please Select\* |
| Email Address |  | \*Please Select\* |

**Additional Information:**

Please email this referral form to: east.midlands@gamcare.org.uk

**For 24/7 support please contact the National Gambling Helpline on: 0808 8020 133**

**Live chat via www.gamcare.org.uk**

**This referral has come through via Double Impact’s Time Out project**