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| **Referral Date:** |
| **Referrer Details**  **Name:**  Contact number:  Organisation name and address (for professionals referring to service)  Email:  Relationship to referee**:** |
| **Referral information**  **Name:**  Address:  Contact number:  Email:  Date of Birth: |
| **This service is not suitable for people with moderate to severe dementia or complex needs.**  **Reason for referral to the Befriending programme:**  **Loneliness Isolation**  **Other**   |  | | --- | | please specify ‘other’ reason |   **Support Required:**  **Telephone Groups Other**  Please explain why you are referring and what type of befriending support is required:  Please answer all the questions below:  Has a referral been made to any other Befriending services? Yes/No  Are there any other organisations or care agencies supporting this person? Yes/No  Is the person able to talk on the telephone by themselves? Yes/No  Does the person have a hearing impairment? Yes /No  Are there any mobility issues? Yes/No  Has this person been in recent contact with any NHS services Yes/No  (apart from this referral contact) |
| **Identifiable risks** pleasesharewith us any safeguarding alerts/risks in detail below where applicable: |
| **Consent:** Has the person named consented to this referral. Yes / No |