|  |
| --- |
| **Referral Form for Befriending Service or Dementia Befriending** |
| **Date of Referral:**  |
| **ONLY complete the referral form if the person you are referring meets ALL the following criteria:*** **aged 55 or over and lives in a household eligible for Barnet Council Tax.**
* **socially isolated with limited support networks and/or has difficulty accessing community services.**
* **capacity to agree to the referral, participate in the assessment process and commit to regular contact over a sustained period.**
* **for the Dementia Befriending Service, the client MUST have a confirmed dementia diagnosis, and be within the mild to moderate range.**

**And*** **You have explained to the client what the service can and cannot offer.**
 |
| Surname:  | Forename:  | Preferred name: |
| Title: Mrs [ ]  Ms [ ]  Miss [ ]  Mr [ ]  Dr [ ]  Other [ ]  |
| DOB: Current age: | Gender: |
| Home address:Postcode:  | Telephone: |
| Mobile: |
| Has the client consented to this referral and the information supplied? **Yes** [ ]  **No** [ ] Client’s Email or that of NOK:Please state client’s ethnicity: Religion: |
| What is the client’s first language? If not English, which language/s does he/she speak?Does the client have any communication difficulties/sensory impairment issues: |
| **Emergency Contact Details**  |
| Surname | Forename | Preferred name |
| Relationship to user: Email: |
| Telephone: | Mobile: |
| **Background Information** |
| Reason for referral? Isolation/loneliness/additional factors?  |
| Client’s interests, desired outcomes, expectations?  |
| **Living situation** |
| [ ] oes the client live alone? Yes [ ]  No [ ] (If no, please state the person(s) they live with and their relationship to the person being referred) |
| Can client let visitors into the home independently? Yes [ ]  No [ ] If no, please give details or access instructions, key-safe?Are there any pets? Yes [ ]  No [ ]  If yes, please give details:  |
| Does the client have any mobility issues? Yes [ ]  No [ ] If yes, please give details:Has the client had any falls in the last year? |
| Please describe the client’s current social contact/support network (including neighbours/ family/ district nurses/day opportunities/activities/ other voluntary sector organisations etc.): Is there a care package in place? Yes [ ]  No [ ] If yes, please provide the name and contact details of the care agency:Is there Telecare in place and which provider? Do they care for anyone? Yes [ ]  No [ ]  |
| Accommodation: Flat[ ]  Sheltered Housing [ ]  House [ ]  Maisonette [ ]  Other [ ]  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Property access issues, steps, lifts, parking:   |
| **Physical Health** |
| Does the client have any physical health needs? Yes [ ]  No [ ] How does this affect the service user?Does the person smoke? Yes [ ]  No [ ] Does the person have: Diabetes [ ]  Epilepsy [ ]  Infectious illness [ ] Any other long-term conditions? |
| **Mental Health or Learning disabilities**  |
| Does the client have any mental health concerns? Yes [ ]  No [ ]  How does this present?Does the client have any learning disabilities?  |
| **Dementia ( Essential for clients to access the Dementia Befriending or Day Services)**  |
| Has the client had a formal diagnosis of dementia? Yes [ ]  No [ ] What type of dementia was diagnosed?Date of diagnosis: Who made the diagnosis?Name of family member to contact:Email: Telephone:Address:Is there a Lasting Power of Attorney in place?Please state who the Attorney is and what for?\*We may request to see proof of LPA.  |
| **Other Information** |
| Does the client have a history or evidence of: Violence/threatening behaviour? Yes [ ] No [ ] Unknown [ ] Substance misuse abuse? Yes [ ] No [ ] Unknown [ ] Self neglect? Yes [ ] No [ ] Unknown [ ]   Are there any issues with their home environment, such as clutter/hoarding or other risks factors for residents and visitors?  |
| Is there anything else that would assist us to provide a service? |
| **GP Details** |
| Name: | Surgery: | Telephone: |
|  **Referrers details**  |
| Name and job title: | Email: | Telephone: |
| What is your involvement with this client and duration of involvement? |  |

**GDPR (General Data Protection Regulation)**

**Information held on our database is strictly confidential and we do not pass on any personal data about you to outside organisations and/or individuals without your express personal consent. The only exception to this might be if there is a crisis and the emergency services need to be given appropriate information. We share anonymised data with the local authority and other funders as part of our reporting obligations.**

**Age UK Barnet may share information about someone without their consent if we are concerned that someone involved in a case is at risk of significant harm. In this case, we may notify a relevant statutory body, for example social services or the police. These disclosures will be done following Adult Safeguarding procedures that our staff and volunteers have been trained in.**

**Any data we hold on you is done so in accordance with data protection legislation and Age UK Barnet’s Privacy Notice. A copy of our Privacy Notice is available on our website at www.ageuk.org.uk/barnet/privacy-notice or on request by calling 020 8203 5040.**

**Please sign below if the client has agreed to this referral.**

**Client’s signature…………………………………………………..… Date…………………….**

**Referrer’s signature………………………………………………….. Date………………….**

**(as witness to clients verbal consent)**

**Please send form to** **befriending@ageukbarnet.org.uk** **for befriending or if there is a confirmed diagnosis of Dementia to** **Rebecca.bayne@ageukbarnet.org.uk**

**Or send to Ann Owens Centre, Oak Lane, East Finchley, N2 8LT, 0208 150 0967.**

If you are unable to complete this form, contact us to see if we can do it together over the phone. The more information we have the quicker we can affectively help your client and many others.