|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Community Companions Referral Form** | | | | | | | | | | | | | | | | | |
| **Date of referral:** | | | | | | | | | | | | | | | | | |
| **Title:** | **Full Name:** (KYN1/2) | | | | | | | | | | | | | | | **DOB:** (KYN3) | |
| **Address:** | | | | | | | | | | | | | | | | **Telephone:**  **Mobile:**  **Email:** | |
| **Emergency Contact:** | | | | | | | | | | | | | | | | | |
| **Name of GP Practice:**  **Telephone Number:** | | | | | | | | | | | | | | | | **Do they have a background in the Armed Forces?**  Yes / No | |
| **Ethnicity:**  (Pleasehighlight) | | White British / White Irish / Other White / Asian Indian / Asian Pakistani / Asian Bangladeshi / Other Asian / Black Caribbean / Black African / Other Black / Chinese / Mixed White and Black Caribbean / Mixed White and Black African / Mixed White and Asian / Other Mixed /  Other Ethnic Group | | | | | | | | | | | | | | | |
| **Reason for Referral:** | | | | | | | | | | | | | | | | | |
| **Are you/they able to leave the house unaided/without support?** Yes / No  **On a scale of 1 – 10, how much support is required to leave the home:**  1 2 3 4 5 6 7 8 9 10 | | | | | | | | | | | | | | | | | |
| **Are you/they currently using any mobility aids? If yes, please state:** | | | | | | | | | | | | | | | | | |
| **Do you/they have any long-term health conditions/disabilities?** YES/NO  (If yes, please specify) | | | | | | | | | | | | | | | | | |
| **If yes, does this disability or illness affect you/they in any of the following areas? Tick all that apply** (KYN35) | | | | | | | | | | | | | | | | | |
| Mobility Impairment | | | | 🞏 | | | | | | | | | | Blind/Visual impaired | | | 🞏 |
| Deaf/Hearing Impairment | | | | 🞏 | | | | | | | | | | Learning Disability | | | 🞏 |
| Neuro-diversity (e.g. ADHD, Autism) | | | | 🞏 | | | | | | | | | | Neurological Condition (Alzheimer’s, Epilepsy) | | | 🞏 |
| Mental Health Difficulty | | | | 🞏 | | | | | | | | | | Other, please describe | | | 🞏 |
| Long term health condition, please describe | | | | 🞏 | | | | | | | | | |  | | |  |
| Dexterity | | | | 🞏 | | | | | | | | | | Memory | | | 🞏 |
| Stamina/breathing/fatigue | | | | 🞏 | | | | | | | | | | Prefer not to say | | | 🞏 |
| **Do you/they have any physical or mental health problems or disabilities that have lasted, or are expected to last 12 months or more?** (KYN33) | | | | | | | | | | | | | | | | |  |
| Yes | | | | 🞏 | | | | No | | | | | | | | | 🞏 |
| Prefer not to say | | | | 🞏 | | | |  | | | | | | | | |  |
| **Does your/their condition(s) or illness(es) reduce your ability to carry out day-to-day activities?** (KYN34) | | | | | | | | | | | | | | | | | |
| Yes, a lot | | | | 🞏 | | | | | | | | | | | Yes, a little | | 🞏 |
| No | | | | 🞏 | | | | | | | | | | | Prefer not to say | | 🞏 |
| **Is the home suitable for Volunteers to attend?** | | | | | | | | **Is there anything in the home to be aware of?**  (large dogs, smoker, hoarder) | | | | | | | | | |
| **Who else lives in your/their household**? | | | | | | | | | | | | | | | | | |
| Client only | | | 🞏 | | | | | | | | | | Living with another person/other people | | | | 🞏 |
| Prefer not to say | | | 🞏 | | | | | | | | | |  | | | |  |
| **Which of the following describes your/their current situation?** | | | | | | | | | | | | | | | | | |
| Employed/Self employed | | | | 🞏 | | | | | | | | Not working/Looking for work | | | | | 🞏 |
| Retired | | | | 🞏 | | | | | | | | Not working and not looking for work | | | | | 🞏 |
| Prefer not to say | | | | 🞏 | | | | | | | |  | | | | |  |
| **What is your/their marital or partnership status?** | | | | | | | | | | | | | | | | | |
| Married or in a civil partnership | | | | | 🞏 | | | | | | Never married/in a civil partnership | | | | | | 🞏 |
| Divorced | | | | | 🞏 | | | | | | Widowed | | | | | | 🞏 |
| Widowed | | | | | 🞏 | | | | | | Separated, but still legally married/in a legally recognised civil partnership | | | | | | 🞏 |
| Prefer not to say | | | | | 🞏 | | | | | |  | | | | | |  |
| **Are you/they a carer?** | | | | | | | | | | | | | | | | | |
| Yes | | | | | | 🞏 | | | | No | | | | | | | 🞏 |
| Prefer not to say | | | | | | 🞏 | | | |  | | | | | | |  |
| **Do you/they have access to a car when needed (either a passenger or a driver)?** | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | 🞏 | | No | | | | | | | | 🞏 |
| Prefer not to say | | | | | | | 🞏 | |  | | | | | | | |  |
| **Are there any safeguarding concerns we need to be made aware of?**  Yes / No  **Further Details:** | | | | | | | | | | | | | | | | | |
| **Any other information:** | | | | | | | | | | | | | | | | | |
| **Client Consent:**  **Do you give consent to Age UK Hull holding your details and contacting you or the referring organisation when it may be relevant to your needs:** YES / NO (verbal / written)  **Do you give consent to Age UK, the national body, viewing your file for quality checking:**  YES / NO (verbal / written)  **Name: …………………………………………………….. Signed:…………………………………………….**  **If the client is unable to provide consent, have you read all the information being provided upon the referral form to the client?** YES / NO  **Do you have consent from the individual named above to make this referral?**  YES / NO  **Name: …………………………………………………….. Signed:…………………………………………….**  **Referring Organisation: …………………………………………………………..**  **Email: …………………………………………………………….. Tel: ………………………………………………..** | | | | | | | | | | | | | | | | | |
| **Email referral form to:** [referral@ageukhull.org.uk](mailto:referral@ageukhull.org.uk)  Tel: 01482 324644  Age UK Hull, Silvester House, Silvester Street, The Maltings, Hull HU1 3HA  Age UK Hull is a registered charity, number 1101418  Further details of our Privacy Policy can be seen on our website www.ageuk.org.uk/hull | | | | | | | | | | | | | | | | | |

Please return to [referral@ageukhull.org.uk](mailto:referral@ageukhull.org.uk)

Silvester House, The Maltings, Silvester Street, HULL, HU1 3HA – 01482 324644