Telephone Befriending Service

Date of referral: ___ / ___ / _____

Title:	**Ethnicity:**	**Full Name:**	**DOB:**

Address:	**Telephone:** **Mobile:** **Email:**
How did you hear about the service?	**Do you have a background in the Armed Forces?** Y / N

Do you have any long term health conditions/disabilities that we need to be aware of?
(If yes, please specify)

Referred by (if different from above):

Name:

Telephone:

Organisation/Role:

Do you have consent from the individual named above to make this referral?
Y / N

Emergency Contacts (PLEASE ENSURE THAT THIS SECTION IS COMPLETED)

In the event of an emergency or if we are unable to contact you, we may need to telephone an emergency contact or appropriate services to check on your safety and welfare.

Name:	Name:
Relation to client:	Relation to client:
Telephone:	Telephone:
Address:	Address:

Name of GP Practice:

Telephone Number:

Please provide any further information that we should know about the individual. This could also include any hobbies, interests or past-times they may have:

Referral completed by (print name): _____

Due to the new EU Data Protection regulations, we require your explicit written consent in order to be able to hold your details to be able to communicate with you. Your details will be kept securely and not passed onto any third party.

Signature: _____ Date: _____

Please ensure that all sections of this referral form have been completed then return to: hello@ageukhull.org.uk

Hull City Council

TwoRidings Community Foundation
Giving across North & East Yorkshire