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**Befriending Referral Form**

**Please Note**

If the client is **not housebound** they may be better being reffered to our Actvities and Events team: [Event@aukc.org.uk](mailto:Event@aukc.org.uk) If they have a diagnosis of **Dementia** they may be able to have specialist support the our Memory Loss Team: [dementia@aukc.org.uk](mailto:dementia@aukc.org.uk) If the client has **complex mental health issues** they may benefit from support from a mental health Befriending specialist such as Hestia.

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| **Client Details** | | | |
| **Title:** | **Surname:** | | **Forename:** |
| **DOB:** | | | **Gender:** |
| **Address:**  **Post Code:**  **E-mail address:** | | | **Next of Kin (if known) / Name and Relationship:** |
| **Telephone Number** | | | **Next of Kin - Tel. No:** |
| **Registered GP details (if known):**  **Name telephone no**  **Address** | | | **Other Professionals involved (if known):** |
| **How did you learn about our Befriending Scheme? Please specify:** | | | |
| **To enable us to contact the client about the service, please speak to the client and provide us with the best day(s) and time for them to receive an initial call from the Programme Coordinator** | | | |
| **Day(s) of the week:** | | **Time of the day:** | |
| **Key service criteria:** | | | |
| Aim: Befriending is a service targeted at isolated older people in Kensington & Chelsea to provide them with Social Interaction.  Any person 55 years of age or over and where one or more of the of the following apply:  Living alone  Feels Isolated  Lacks a local social support network such and family and friends.  Housebound, poor mobility, or unable to go out alone  Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has the client consented to this referral? **Yes/No** (if not please get consent)  Is the client willing/able be able to engage in social contact? **Yes/No**  Does the client live in a safe environment for a volunteer to visit? **Yes/No**  (If not, any such issues would need to be addressed before the client can be supported with befriending.)  Is the client digitally connected or able to do so? **Yes/No** | | | Circumstances we need to be aware of in order to provide a better and more personalised service.  *(please tick as appropriate):*  Diagnosed with major depression or anxiety.  Hearing Impairment  Visual Impairment  History of falls  Drink/Drugs issues  Dementia/Alzheimer’s  Mental Health issues  Mobility Impairment  **Please Note:**  Age UK Kensington and Chelsea may not be able to provide this service if we consider it the case that we will not be able to appropriately meet a client’s needs. |
| How will the client benefit from the Befriending?  **C** | | |  |
| **Referrer Details** | | | |
| Referrer Name  Address | | | Tel. no  E-mail: |
| Job Title/Designation/Family Member | | | Organisation: (If applicable) |
| Does the client speak another language Yes/No  If yes, please give details, i.e. what languages and what degree of fluency | | |  |

# THE VOLUNTEER VISITOR AND THE VISIT

Would the client prefer the visitor to be? **Older Younger Does not mind**

Would the client prefer the visitor to be? **Male Female Does not mind**

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| **Please give any further relevant supporting information regarding this referral:** |

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete electronically as a word document and send form to:**

Wporter@aukc.org.uk