**Form completed by: Date:**

|  |  |
| --- | --- |
| **Surname:**  | **Forename:**  |
| **DOB:**  | **Ethnicity:**  |
| **Communication Needs:**  |
| **Address:****Postcode:**  | **Telephone:****Alternative number:** |
| **NOK name:** | **NOK relationship:**  |
| **NOK contact details:**  |
| **Referrer name and contact details:** | **Contact person from Social Care/Community Team or G.P:** |
| **How did customer/referrer hear about service?:** |

|  |  |
| --- | --- |
| **Shopping service required:**Limited period □Regular on-going □ | **Customer informed of**Supermarket choice □Delivery charge □ |
| **Reason for referral:****How does the referred person currently shop for food?****Will the order normally be for more than one person at this address?****Allergies requiring Treatment with Epi pen:****Special Diet Requirements:** **Access Arrangements:****Any pets in the property? Y/N****Known risks for delivery volunteers associated with the referral:** |

**Please return to:** **food2you@ageuklands.org.uk** **Tel. 020 7358 4064**