Please complete this referral form and email [advice@ageuknorfolk.org.uk](mailto:advice@ageuknorfolk.org.uk) or by telephone 0300 500 1217 or for help.

**Age UK Norfolk’s Gift of Friendship project.**

Our Gift of Friendship project takes a proactive, goal-oriented approach to helping individuals aged 50+ reduce loneliness and social isolation across Norfolk.

* **Face-to-Face Befriending:** This service fosters meaningful connections through friendly visits, whether at a person’s home or care facility. Our volunteers provide companionship and support to help individuals achieve their personal goals.
* **Telephone Befriending:** For those who prefer or require remote support, our goal-oriented telephone befriending service offers regular conversations to build connection and encourage personal growth.

We tailor our approach based on individual needs, ensuring a supportive and engaging experience.

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| **DATE OF REFERAL** |  |

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| **REFERRER’S DETAILS** | | | | | |
| **Does the service user consent to the referral?**  *We are unable accept referrals unless permission to refer has been given by the person you are referring.* | | | | Yes | No |
| **Name:** |  | **Relationship / organisation:** |  | | |
| **Email:** |  | **Your ref/LAS No:** |  | | |
| **Telephone:** |  | **Telephone:** |  | | |

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| **DETAILS OF SERVICE USER** | | | | |
| **Title:** |  | **Full Name:** | |  |
| **Date of Birth:** |  | **Preferred name:** | |  |
| **Phone No:** |  | **Mobile No:** | |  |
| **NI No:** |  | **Email:** | |  |
| **Home Address:** |  | | | |
| **Type of residence** (care home/ own property / sheltered accommodation) | | |  | |
| **Please consider suitability for our service** | | | **Comment:** | |
| Do they have hearing loss or speech impediment which could make conversations on the telephone difficult? | | |  | |
| Do they have high level mental health needs or are they receiving treatment or clinical support? | | |  | |
| Do they experience extreme mood swings or personality changes that could make the call challenging for a volunteer? | | |  | |
| Do they have a history of aggression, inappropriate conversation, or threatening behaviour? | | |  | |
| Do they have any significant memory loss issues? We would not wish calls to cause any distress. | | |  | |
| Do they have a drug or alcohol problem and are still receiving treatment? | | |  | |
| Are they difficult to get hold of by telephone on a regular basis, from a withheld number? | | |  | |
| Who does the service user live with? | | |  | |

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| **Are there any risk issues we need to be aware of to themselves or to others?** |
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| **Please provide the reason for the referral, specifying whether the individual prefers face-to-face meetings or telephone support. Additionally, include any relevant details that could assist Age UK Norfolk in delivering the Gift of Friendship service in the most meaningful way for the person being referred.** |
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**Alternative Contact**

We require an alternative contact, preferably who is local, it can be a family member, neighbour or friend who we can call if we have concerns about the service user or are unable to make contact with them. We suggest the nominated person/s are informed that Age UK Norfolk have their details and may call.

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| **Next of Kin / Alternative contact** | | | |
| First name: |  | Surname: |  |
| Telephone: |  | Relationship: |  |
| Do they live locally to you? | Yes/No | | |
| Permission to contact if you are unreachable? | Yes/No | Discuss health or welfare concerns? | Yes/No |

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| --- | --- | --- | --- |
| **Details of any care being provided** | | | |
| Care Agency Name: |  | Phone: |  |
| Frequency of care: |  | | |

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| --- | --- | --- | --- |
| **Any other friends or family who provide support** | | | |
| Title: |  | Name: |  |
| Phone: |  | Relationship to service user: |  |
| Address: |  | | |
| Has the service user given permission for them to be contacted? | Yes/No | Do they hold LPA? | Yes/No |
| What support are they providing? |  | | |