# Enabling Connections Referral Form

| Personal Details | |
|---|---|
| Surname: | |
| Forename: | |
| Mr/ Mrs/ Miss: | |
| Address: | |
| Post code: | |
| Tel. no: | |
| Date of Birth: | |
| Next of Kin: | Tel. no: |
| Relationship: | |
| Emergency Contact – (if Different) | |

| Medical Information | |
|---|---|
| GP surgery: | |
| Tel. no: | |
| Details of illness/disabilities: | |
| Other Professions/Services Involved (please specify): | |

| **Home Situation and Current Circumstances** | |
|---|---|
| Does the client live alone? Y/N<br><br>Does the client live in a HMO or other shared accommodation setting? Y/N<br><br>Are there any home environment issues we should be aware of? e.g hoarding, property condition Y/N<br>(If Y please provide more detail)<br><br>Are there any pets kept at the property? Y/N/ unknown<br>(if Y please specify)<br><br>Any access issues? Keysafe, steps, etc? | |
| Is the client currently experiencing loneliness or isolation? Y/N | |
| Has the client experience any of the following within the last 12-24 months? (tick all that apply) | □ Bereavement<br>□ House move or relocation<br>□ Hospital admission or discharge<br>□ Fall affecting confidence<br>□ Health condition impacting independence or community participation |
| Does the client have the capacity and willingness to engage in face-to-face visits and guided conversations? Y/N | |
| Would the client benefit from support to: | □ Rebuild confidence<br>□ Increase independence<br>□ Develop social connections<br>□ Reconnect with community activities<br>□ Identify and wok towards person goals |
| Briefly describe the goals the client may wish to achieve through the programme: | |
| Are you aware of any potential risks to staff/volunteers visiting this client on their own? Y/N (If Y, please clarify)<br><br>Is there any other relevant information we need to know before introducing a client to social/groups activities? Y/N<br>(If Y, please clarify) | |

| **Reason for Referral: Please provide a brief summary of the referral and why the client would benefit from the Enabling Connections Programme:** Please provide some background/social history as well as any details of interests and hobbies. |
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| **Referral Agent** | |
|---|---|
| Name: | Role: |
| Email: | |
| Tel No: | |
| Date of referral: | |
| Is client aware of this referral Y/N: | |

| **Consent** | |
|---|---|
| Has the client/NOK given consent for personal information to be given and stored by Age UK Oldham? | Yes/No |
| **Security of Data** | |
| All client data is stored in a secure database and will be used only for the purposes of delivering the Enabling Connections Programme.<br><br>No client will ever be contacted with marketing unless they have done so through another channel.<br><br>The client has the right to withdraw consent at anytime by contacting Age UK Oldham by email; careandsupportservices@ageukoldham.org.uk or telephone; 0161 6229288.<br><br>If consent is withdrawn we can no longer provide the service.<br><br>All client data is held for 8 years from the closing date of the record for legal and business purposes. | Has the client been made aware of this Yes/No |

**Please return completed form to:**
**careandsupportservices@ageukoldham.org.uk**