Referring older people to Age UK Westminster's Befriending Service

I enclose a copy of our current referral form. If you have any copies of any old forms I would be grateful if you would destroy them. The enclosed form can be photocopied for future use.

Our services are aimed at older people (60+) who are:

housebound
living alone
isolated
lonely
and have agreed to be referred to Age UK Westminster.

The Befriending service provides companionship and support, but please note that our Befriending volunteers are not qualified carers. Befriending Volunteers do not have Mental Health training and it is with regret that we cannot provide Befriending services for people who have significant Mental Health problems or cases where the client has been diagnosed with advanced stages of Dementia whereby specialist training and support would be required. We are also unable to provide assistance for wheelchair users (pushing wheelchairs) as volunteers are not trained in this area. Due to demand priority will be given to those clients who live alone and do not have any family members living in the same household.

Please email the referral form to Age UK Westminster using the details below,

Warm Regards,

Email: enquiries@ageukwestminster.org.uk

Tel Reception: 020 3004 5610

Age UK Westminster
Beethoven Centre
Third Avenue
London
W10 4JL

t 020 3004 5610
e enquiries@ageukwestminster.org.uk
www.ageuk.org.uk/westminster

Please complete as fully as possible. Thank you.

Client Details

Name:	DOB
Address: Postcode: Telephone:	Is the client aware of this referral? ☐Yes ☐ No Ethnicity: Preferred Language: Are there any other communication needs? ☐ YES. ☐ NO Please specify:
Reason for referral:	
Does the client live:	☐ Alone ☐ With Partner ☐ With Family ☐ Other - specify
Mobility:	☐ Independent ☐ With aids-specify ☐ With assistance ☐ Dependent
Health: Medical Diagnosis:	☐ Physical Disability ☐ Mental Disability ☐ Other - specify
Eye Sight: Good/Poor/Glasses/Visually Impaired	Hearing: Good/Poor/Hearing Aid/
Continent: ☐ YES. ☐ NO	Speech: Clear/Slurred/None

What support does the client receive?

☐ Family	☐ Neighbours	☐ Friends
☐ Day Centre	☐ M.O.W.	☐ Home help
☐ District Nurse	☐ Care Manager	☐ Health Visitor
☐ Carer:	☐ Other - Please specify	

Other contact details:

GP's Name Address: Postcode: Telephone:	Next of Kin Contact - in case of emergency Name: Address: Telephone: Relationship:

Would the client prefer telephone befriending or telephone befriending up until a suitable befriending match is made? ☐ YES. ☐ NO
Are there any cultural, religious or language factors that we should be aware of?
Any additional comments:
Any known risk or hazards to lone workers: ☐ YES. ☐ NO Please list potential hazards for staff and volunteers to be aware of e.g. potentially violent or aggressive behaviour/ dangerous dogs/ isolated property /hoarding.

Referrer's Details:	
Name: Relationship to client: Telephone:	Organisation: Job Title
Signed by referrer:	Date of referral:
Office Use Only: Date Received: By: Date Assessed: By: Accepted/Declined/Referred to other services: Allocated to:	