Age UK Bolton is pleased to offer one-to-one befriending support and friendship to older people who live alone, are socially isolated and experiencing feelings of loneliness.

By completing this referral form, you confirm that your client has agreed to the referral and is happy to be contacted by one of our Service Co-ordinators.

Please ensure our consent box is signed on the final page.

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| BEFRIENDING |
| Lesley Simm & Vicky Urmston 01204 701525 ageingwell@ageukbolton.org.uk  |
| Please be aware we do not cover Horwich, Halliwell, Blackrod or Westhoughton as they have their own independent visiting services. If you are unsure of areas, please contact a service co-ordinator prior to referring.  |

All information given in this form will be treated in line with Age UK Bolton’s Data Privacy and Confidentiality Policy. This is available to read on our website.

**Before proceeding please confirm**

Client is aged 65 or over

Client lives alone

Client is socially isolated (and rarely gets out independently)

Client is experiencing feelings of loneliness

Client actively wishes to have a befriender

Client consents to the referral

**Can Accept Unable to Accept**

Low mood Suicidal thoughts

Mild Forgetfulness Clinical depression

 Complex mental health illness (including advanced diagnosis of

 dementia)

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| **Date of referral** | **Date of Assessment** | **Date of Match** |
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| **1. Referral Information – please tick which befriending is requested** |
| **Referral Type: Face to Face Befriending Telephone Befriending**  |
| **Reason for Referral:** |
| Referred by:  | Relationship to client:  |
| Organisation: | Telephone number: |
| Email: | Date of referral:  |
| **2.Client Details** |
| Gender: Female Male Other  |
| Name in full:  |
| Title: Mr Mrs Miss Ms Other (please state) |
| Address:  |
| Post Code:  |
| Telephone number:  |
| Date of Birth: --/--/---- **Are they 65 or over?** Yes / No\* \*If no, sadly we are unable to accept.  |
| **Do they live alone?** Yes \*No \*If no, sadly we are unable to accept the referral.Notes:  |
| Languages spoken: English Urdu Guajarati Other (please state) |
| Social Worker: Contact No: |

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| **3.Next of Kin (If not, is there a neighbour or friend we can contact?)** |
| Full name:  |
| Relationship to Client:  |
| Address: |
| Post Code: |
| Telephone number: (**Essential)** |
| Is next of kin aware of referral? Yes No Does the client wish N.O.K. to be present at assessment? Yes No Is the client happy for their befriender to have their N.O.K. contact details? Yes No  |

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| **4. Mental Health - must be completed fully or please tick ‘None** |
| **Is your client experiencing or have they been diagnosed with a complex mental health illness (including an advanced diagnosis of dementia)?** **If Yes – We are sorry we are unable to accept the referral.****If No, please continue below.** |
| **Please tick any wellbeing concerns** None  Recently bereaved  Mild forgetfulness  Low mood | **Please give details if relevant** |

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| **5. Physical Health Conditions E.g: mobility issues, sensory impairment, epilepsy, seizures, heart problems, COPD, diabetes.** Please note our volunteers are not trained in health conditions and are unable to provide practical support with any of the above conditions. If the client thinks they might like the volunteer to take them out we will need to find a suitable volunteer and conduct a risk assessment first. |
| **Please tick any physical health illnesses.** None  Mobility needs Sensory impairment  Epilepsy/seizures  |  Heart condition  COPD  Cancer diagnosis  Diabetes Hearing impairment Sight impairment   |
| **Do they use any mobility aids or devices? Please state.****Please provide further details or list any other illnesses.** |

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| **6. Safeguarding** |
| *Are there any concerns regarding the person’s safety either inside or outside the home, e.g. falls, seizures, access. If no, please state NONE. If yes, please provide full details:*  |

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| **7. Interests / Hobbies / Previous Employment** |
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| **8.Property Information e.g., Key Safe number, entry code, isolated property etc.** |
| **3.i. Do they Smoke?** |
| **3.ii. Do they have any Pets?** |
| **3.iii. Are they a veteran of the Armed Forces?** |
| **3.iv Is there a Key Safe / entry code? Yes No Code:**  |
| **3.v Do they have CareLine or similar? Yes No** **Details:** |
| **3.vi Other property information needed: (*please state*)** |

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| **9. Additional Emergency Contact / key holder e.g., neighbour, Careline**  |
| Name: Telephone number:Address: |
| Housing Officer: Contact: |
| Scheme Manager: Contact: |
| **10. Visiting Preferences** (We will do our best to meet the client’s preferences but are dependent on the availability of the volunteer) |
| Preferred days and times:Male / Female volunteer preferred:  |

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| **11. Consent** **(Please complete. This is an essential section for GDPR and Data Privacy.)**In order to help you, we need to store information about you. The law says that we must get your consent to do this. Everything you tell us will be treated confidentially and your data will be subject to the data protection legislation and General Data Protection Regulations. Records will be kept securely for 6 years and then securely destroyed. You can withdraw consent and request access to your records at any time.Please note: any form of harassment or sexual harassment against any of our staff will not be tolerated and may result in us having to remove our help and support from you.**(a) I consent to Age UK recording personal** **information about me: YES / NO****(b) I know that Age UK Bolton’s Data Privacy Notice is available for me to view on their website or I can request a printed copy if I need it.**  <https://www.ageuk.org.uk/bolton/privacy-policy> **YES / NO**

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| Name | Signature | Date |
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| If consent provided verbally or by telephone, please delete as necessary and sign belowService Lead / Referring Partner / Family Member/ Carer / Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Verbal Consent:  |

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