

**Please Return to:**

Age UK Cambridgeshire and Peterborough

Sharing Time Team

Frans House

Fenton Way

Chatteris

PE16 6UP

E: sharingtime@ageukcap.org.uk

**TELEPHONE BEFRIENDING**

**REFERRAL FORM DATE OF REFERRAL:**

 **CHARITY LOG NUMBER:**

|  |
| --- |
| **SERVICE USER DETAILS If completing form electronically please tab through each section** |
| Title |  |
| Surname |  |
| First Name |  |
| Known As |  |
| Telephone No |  |
| Home Address |  |
| Current Address (if different) |  |
| AREA/District |  |
| Marital Status |  |
| Gender |  |
| Date of Birth |  |
| Religion |  |
| Ethnic Group |  |
| **Has the service user given their permission for this referral and for information shared to be stored on our database?** | [ ] Yes [ ] No  |
| **NEXT OF KIN DETAILS** |
| Full Name |  |
| Relationship |  |
| Address |  |
| Telephone No |  |
| **REFERRER DETAILS** |
| Name |  |
| Relationship |  |
| Address |  |
| Telephone No |  |
| Email Address |  |
| **Alternative contact name and details if referrer is unavailable** |  |
| **MEDICAL DETAILS** |
| **In order to safeguard the older person and volunteer, we ask that all known physical and mental health conditions are declared. Failure to do so can put both parties at risk and may result in us being unable to continue with the referral.** |
| Medical Conditions/History |  |
| Critical Information |  |
| **REASON FOR REFERRAL (Please provide as much information as possible)** |
|  |
| **EMERGENCY CONTACT DETAILS** | **NAME** | **ADDRESS** | **TELEPHONE NO** |
| Family Contact |  |  |  |
| Emergency Contact/Key holder |  |  |  |
| Doctor |  |  |  |
| Other |  |  |  |
| **What contact have you had with this individual?** | [ ] Face to Face [ ] Telephone  |
| Preferred Gender of Volunteer | [ ] Male[ ] Female[ ] No Preference |
| Hobbies or Interests the service user enjoys |       |
| **COMMUNICATION OPTIONS** |
| Does the service user have Internet Access | [ ] Yes [ ] No  |
| Does the service user use any of the following devices | [ ] Smart Mobile Phone [ ] Tablet Device/iPad [ ] Laptop/Computer  |
| Does the service user have an email address | [ ] Yes Email address      ……………………..[ ] No  |
| What is the service user’s preferred spoken language? |       |
| How did you hear about the Telephone Befriending Service? |       |

**I**       **(name of referrer) confirm that the information shared above is accurate to the best of my knowledge and with the consent of the older person. I confirm that all known risks to the older person, volunteer and Age UK CAP staff have been declared.**

**I understand that the service is delivered by befriending volunteers who have no specialist training and are unable to provide medical, care or therapeutic services in any form. This service should not replace and does not constitute support from trained professionals.**

**Signed:**

**Dated:**

**Please note that any incomplete or unsigned forms will be rejected.**