|  |
| --- |
| A logo with text and a ribbon  Description automatically generated with medium confidence**Community Companions Referral Form** |
| **Date of referral:**  |
| **Title:** | **Full Name:** (KYN1/2) | **DOB:** (KYN3) |
| **Address:** | **Telephone:** **Mobile:****Email:** |
| **Emergency Contact:** |
| **Name of GP Practice:** **Telephone Number:** | **Do they have a background in the Armed Forces?**Yes / No |
| **Ethnicity:**(Pleasehighlight) | White British / White Irish / Other White / Asian Indian / Asian Pakistani / Asian Bangladeshi / Other Asian / Black Caribbean / Black African / Other Black / Chinese / Mixed White and Black Caribbean / Mixed White and Black African / Mixed White and Asian / Other Mixed / Other Ethnic Group |
| **Reason for Referral:** |
| **Are you/they able to leave the house unaided/without support?** Yes / No**On a scale of 1 – 10, how much support is required to leave the home:**1 2 3 4 5 6 7 8 9 10  |
| **Are you/they currently using any mobility aids? If yes, please state:** |
| **Do you/they have any long-term health conditions/disabilities?** YES/NO(If yes, please specify) |
| **If yes, does this disability or illness affect you/they in any of the following areas? Tick all that apply** (KYN35) |
| Mobility Impairment | 🞏 | Blind/Visual impaired | 🞏 |
| Deaf/Hearing Impairment | 🞏 | Learning Disability | 🞏 |
| Neuro-diversity (e.g. ADHD, Autism) | 🞏 | Neurological Condition (Alzheimer’s, Epilepsy) | 🞏 |
| Mental Health Difficulty | 🞏 | Other, please describe | 🞏 |
| Long term health condition, please describe | 🞏 |  |  |
| Dexterity | 🞏 | Memory | 🞏 |
| Stamina/breathing/fatigue | 🞏 | Prefer not to say | 🞏 |
| **Do you/they have any physical or mental health problems or disabilities that have lasted, or are expected to last 12 months or more?** (KYN33) |  |
| Yes | 🞏 | No | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **Does your/their condition(s) or illness(es) reduce your ability to carry out day-to-day activities?** (KYN34) |
| Yes, a lot | 🞏 | Yes, a little | 🞏 |
| No | 🞏 | Prefer not to say | 🞏 |
| **Is the home suitable for Volunteers to attend?** | **Is there anything in the home to be aware of?**(large dogs, smoker, hoarder) |
| **Who else lives in your/their household**? |
| Client only | 🞏 | Living with another person/other people | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **Which of the following describes your/their current situation?** |
| Employed/Self employed | 🞏 | Not working/Looking for work | 🞏 |
| Retired | 🞏 | Not working and not looking for work | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **What is your/their marital or partnership status?** |
| Married or in a civil partnership | 🞏 | Never married/in a civil partnership | 🞏 |
| Divorced | 🞏 | Widowed | 🞏 |
| Widowed | 🞏 | Separated, but still legally married/in a legally recognised civil partnership | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **Are you/they a carer?** |
| Yes | 🞏 | No | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **Do you/they have access to a car when needed (either a passenger or a driver)?** |
| Yes | 🞏 | No | 🞏 |
| Prefer not to say | 🞏 |  |  |
| **Are there any safeguarding concerns we need to be made aware of?**Yes / No**Further Details:** |
| **Any other information:** |
|

|  |
| --- |
| **Client Consent:****Do you give consent to Age UK Hull holding your details and contacting you or the referring organisation when it may be relevant to your needs:** YES / NO (verbal / written)**Do you give consent to Age UK, the national body, viewing your file for quality checking:**YES / NO (verbal / written)**From time to time, we may like to contact you, please let us know which of the following you would be happy to receive and how you would like us to contact you:**Information on donations and legacies Information on our services, events and promotions, including our Christmas Shoe Box Hampers  Charity Newsletter I do not wish to hear from you Post Email  Email address: Telephone  Name: …………………………………………… Signed:……………………………………………. |
| **If the referral has not been completed by the client:****If the client is unable to provide consent, have you read all the information provided upon the referral form to the client?** YES/NO**Referral completed by:**Name: Telephone: Email:Organisation/Role (if applicable):Signed: |

Please return to referral@ageukhull.org.uk350 Preston Road, Hull, HU9 5HH – 01482 324644Age UK Hull is a registered charity, number 1101418Further details of our Privacy Policy can be seen on our website www.ageuk.org.uk/hull |