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| **Connecting With Your Community**  **Referral Form** | | | | | |
| **Connecting with your community is a befriending project, focusing on reducing loneliness and isolation within the Torridge area. All of our befrienders are volunteers.**  **Clients can be offered the choice of Face-to-Face Visits or Telephone calls, please bear in mind we have a limited number of befriending volunteers, and each referral will be assessed and prioritised on the individual's needs. We cannot guarantee that each referral will have a befriending volunteer matched to them.** | | | | | |
| ***\*This service does not support the provision of either CARE or PRACTICAL HELP.*** | | | | | |
| **Date of Referral** | | **Referred by (Organisation)** | | | |
| **Name of Referrer** | | | **Position** | | |
| **Email Address** | | | **Contact Number** | | |
| **Client Details** | | | | | |
| **Consent to this referral. If you are referring a client please ensure that you have their consent to do so? YES/NO** | | | | | |
| **First Name** | **Preferred Name** | | **Surname** | | **Mr/Mrs**  **Miss/Ms/Other** |
| **Date of Birth** | | **Gender- Male/Female/Other** | | | |
| **Email Address** | | | **Contact Telephone Number** | | |
| **Address** | | | | | |
|  | | | | **Postcode** | |
| **Does the client have any befriending from any external organisations?** | | | | | |
| **Does the client live with anyone? Please state relationship:** | | | | | |



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| **Relevant Client Information (required to facilitate a befriending relationship)** | | | |
| **Does this client have mobility problems e.g (hard of hearing, a history of falling or other?)** | | | |
| **Have you visited the client's home? (please include**  **a date)** | **If YES is there anything that we need to be aware of before a coordinator/volunteer enters the home (trip**  **hazards, uneven access)** | | |
| **Does the client smoke?** | **Does the client have any pets?** | | **Is the client a hoarder?** |
| **If you have answered YES to any of the above, please give further details.** | | | |
| **Client's Wellbeing** | | | |
| **Main reason for requiring the befriending service, i.e loneliness or social isolation. Please use this space to tell us about your client.** | | | |
| **Please be aware that although we will strive to offer your preference, availability will be dependent upon the availability of our volunteers and their location. Please consider the following options.** | | | |
| **Telephone befriending** | | **In Person Befriending** | |
| **Please return this form to:** [**neighbourhood@ttvs.org.uk**](mailto:to:neighbourhood@ttvsorg.uk) **or 14 Bridgeland Street, BIDEFORD, Devon. EX39 2QE** | | | |
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