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| **Befriending Plus**  **Criteria and Referral form** |  |  |

**Eligibility:**

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| **Essential Criteria** |
| Westminster resident |
| Over 60 years old |
| Living alone or with limited social companionship |

**Service exclusions:**

|  |
| --- |
| **Exclusions** |
| Mid/advanced dementia or Alzheimer’s or mental health issues |
| Severe hearing impairment |
| (For face to face Befriending) – High care needs with no carer support e.g.  needs lifting, cannot transfer from a wheelchair |

**Referring to the service**

Please complete the form as fully as possible and email it to the project coordinator at [wellbeing.service@nhs.net](mailto:wellbeing.service@nhs.net). This is a secure email address that must be used for the referral process. For any queries, please contact Natalie Castro on **07484 542228**

**Please ensure that the person you are referring is aware of the referral and inform them that someone from One Westminster will be in touch over the phone about befriending.**

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|  | **CONTACT DETAILS – PERSON INTERESTED IN THE SERVICE** |

|  |  |
| --- | --- |
| **Title:** |  |
| **First Name:** |  | **Last Name:** |  |
| **Date of Birth:** |  | **Must be aged 60 and over** | |
| **Current address:** |  | **Postcode:** |  |
| **Tel:** |  | **Mob:** |  |
| **E-mail:** |  | | |

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|  | **ADDITIONAL INFORMATION**  **Please try to complete all fields** |

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| --- |
| **Reasons for requesting a Volunteer Befriender:** |
|  |
| **Level of family or social interaction at the moment:** |
|  |
| **Relevant medical history, including mental health and physical:** |
|  |
| **Support in place, including a care package:** |
|  |

|  |  |
| --- | --- |
| **Ethnicity:** |  |
| **Preferred language:** |  |
| **Hearing:**  **Good/Poor/Hearing Aid:** |  |
| **Eye Sight: Good/Poor/Glasses/Visually Impaired** |  |
| **Mobility:**  **Independent/With aid assistance/ Dependent** |  |

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|  | **EMERGENCY CONTACT DETAILS** |

|  |  |
| --- | --- |
| **Family/Friend/Neighbour/Other** | |
| **Name:** |  |
| **Relationship:** |  |
| **Tel:** |  |
| **Mob:** |  |

**These will be shared with the volunteer in case of an emergency**

|  |  |
| --- | --- |
| **GP surgery:** |  |
| **Contact number:**  **(if available)** |  |

|  |  |
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|  | **REFERRER’S DETAILS (IF APPLICABLE)** |

|  |  |
| --- | --- |
| **Name:** |  |
| **Organisation/Relationship:** |  |
| **Telephone:** |  |
| **Email:** |  |

|  |  |
| --- | --- |
|  | **REFERRAL SIGNATURE AND DATE** |

|  |  |  |  |
| --- | --- | --- | --- |
| **I understand that the provision of this service is subject to a successful telephone or home visit assessment.** | | | |
| **Signed** |  | **Date of referral:** |  |