*Dear Referrers….*

*Please follow up all referrals with a phone call with regards to any information or concerns you have regarding the person you are referring. This is to ensure that we are able to provide the best and most suitable service for people. Things that we need to be aware of are family issues, mental health issues, any issues around privacy that the older person is not willing to discuss or anything else that you are aware of that may affect ourselves or a volunteer visitor.*

*Our steering group have also requested that we carry out initial assessments with the attendance of yourselves where reasonably possible. This is to ensure the safety and well-being of all involved.*

**Referral Form – BeFriend Kildare Service**

***Please read the Befriending Service Referral Information Sheet at the bottom before completing the form.*** ***Where possible please complete this form with the person who is being referred. Please note that referral forms must be accompanied/followed up with a phone call in order to proceed to an assessment.***

|  |  |
| --- | --- |
| **Details of Person Referred:** | |
| **Name** |  |
| **Address (please provide an Eircode)** |  |
| **Phone Number** |  |
| **Date of Birth**  *Age must be 60+* |  |
| **Please State One Emergency Contact Person**  *Name, Relationship, Contact Details etc.* |  |

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| --- |
| **Type of Referral:**  External Agency  Internal Referral  Self-Referral  Family/Friend |
| **If not a Self-Referral please provide Referrer Contact Details:** (Name, Contact Number, Organisation, Email, etc.) |
| **If this is not a self-referral, is the person aware that the referral is being made?**  Yes  No  *It is essential that the person being referred is aware of the referral and wants to be referred for befriending.* **Please ensure you have the consent of the person you are referring confirmed by asking them to sign here.** |
| **How did you hear about the Befriending Service?**  Word of Mouth  Media/Advertising  Website  Other Agency/Colleague  Other |

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| **What are the Primary Reasons leading to this referral?**  **Do you/the person referred live alone?** Yes  No |

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| --- |
| **Other Information** |
| **Is there any other information which you feel is relevant for BeFriend Kildare to know before assigning a volunteer to this visit? This section includes information on any circumstances; lifestyle, medical, psychiatric or any other issues which may need further discussion.** |

**Also please note that as there is more than one befriending service in the county, by ticking this box you are consenting to your information being shared with other services who may be in a position to offer a volunteer.**

|  |  |
| --- | --- |
| **Referrer Name:**  **Referrer signature:** | **Date:** |

**Return to:** [***befriendkildare@gmail.com***](mailto:befriendkildare@gmail.com) ***or alternatively you can post the complete form to Older Voices Kildare, County Kildare Leader Partnership, Jigginstown, Naas, Co.Kildare W91 A2XE***