HAND OF SOLACE

Giving a hand of support and empowerment

Charity No. SC048192

Elderly Support Service- Befriending Service) Referral Form

Please note that all information supplied will be treated as confidential

Name of person:
Address: Tel no:
Email Address
GP Address Tel no:
Please tell us anything about your current health and wellbeing situation:
Current network of support i.e. community nurse, family member etc. which you feel may be relevant:
Referee's date of birth;
What do you hope the Befriending Service involvement will achieve? ***Please tick the top three that most apply****:*

Reduced feelings of Isolation:	
Reduced feelings of anxiety:	
Improved levels of wellbeing:	
Improved levels of self-esteem/confidence:	
Improved quality of life:	
Increased independence:	
Increased social links:	
Companionship:	
Assistance with a personal goal:	

Please give details of anyone we can contact in case of concern (Relative, friend, neighbour or social worker). Please supply name, email address, postal address and telephone number:	
Is there anything else we should know?	
Signed:	Date:
If this form is been completed by a family member or Health or Social Care Professional please supply the following details: ***(please note that incomplete forms will be returned to referrer)***	
Name of Referrer:	
Relationship to person:	
Address of Referrer:	
Contact Number of Referrer:	

Email address of Referrer:
Please state whether in your opinion it is safe for the person referred to be taken out of their home on escorted visits Yes or No?
Have you carried out a risk assessment for this person? (to be completed by a Health or Social Care Professional) Yes □ No □ If yes – please attach to this form
Do you or anyone else want to be present on an assessment visit? Yes □ No □ If yes, please supply contact details:
Please remember that we will not accept referrals unless permission to refer and to pass on information has been given by the person you are referring. Does this person know that they are being referred? Yes □ No □
Referrer signature:
Date:

Please return completed form to:

Hand of Solace

11 Goodhope Garden
AB21 9NG, Aberdeen

Telephone: 01224 954487; 07378432436
Info@handofsolace.co.uk

Risk Assessment

Does the client have any criminal convictions?	Yes ☐	No ☐
If yes, please provide details of conviction		
Areas of risk to self (if there is a known risk to self, please give full details)		
Areas of risk to others (if there is a known risk to others please give full details)		
Additional Information (is there other relevant information or areas of concern that we need to be aware of eg unusual or aggressive behaviour?)		