Befriending Service Referral Form

Details of referrer

Full Name :

(PLEASE USE CAPITAL)

Address : _____

Phone Number : _____

E-Mail : _____

Job title/relationship to person you are referring : _____

Consent obtained for referral : ☐ Yes ☐ No

Please confirm the person being referred meets all of the eligibility criteria for the service

Lives alone in Hartlepool : ☐ Yes

Aged 65 years or older : ☐ Yes

Lonely and isolated (has contact with friends and family less than 3 times per week ☐ Yes

Please confirm what the person is being referred for

Telephone befriending : ☐ Yes

Face to face befriending : ☐ Yes

Activities ☐ Yes

Details of client

Name : _____

Address : _____

Phone Number : _____

Email : _____

P.T.O .....

Any further information

(including communication needs and potential risk to staff and volunteers, if no risk, please state):

FOR MORE INFORMATION CONTACT

befriending@clevelandfire.gov.uk

01429 872311