Details of referrer

Full Name



**Befriending Service Referral Form**

(PLEASE USE CAPITALS)

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 

Aged 65 years or older

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

Please confirm what the person is being referred for

Telephone befriending

Face to face befriending 

Activities

Details of client

Name Address

Phone Number

Date of birth

Email

Preferred method of contact Phone Email

Letter

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](mailto:befriending@clevelandfire.gov.uk)

**01429 872311**