hello@mkhelpinghands.org.uk

Referral Form and Information

Mearns kirk Helping Hands

Befriending Project

**Referral Criteria**

* **This referral form, including the consent form at the end, must be fully completed, with all information provided. If a form is not fully completed MKHH will have insufficient information to assess suitability. The referral form will be returned to the referrer and no further action will be taken on the referral until it is returned to us fully completed. If a waiting list is in operation, the person referred will not be added to the list until the fully completed form is received.**
* People who are referred for a befriender must be aged 70 or over, living in East Renfrewshire and should self- identify as being isolated and/ or lonely.
* We cannot provide befrienders for people who are living with dementia. If a person living with dementia wishes to increase their social support, you can make a referral to our Lunch Club for People Living with Dementia.
* We are also cannot provide befrienders for people who are resident in care homes.
* We cannot accept self- referrals, or referrals from family members, friends, or acquaintances. Referrals can only be made by a health professional, agency, or other organisation that the individual is known to.
* People being referred should not already be also not in receipt of any other services providing social support or companionship.

**Referral Form: To Be Completed by Referrer Alongside Person Being Referred**

|  |  |  |
| --- | --- | --- |
| Date of Referral |  | |
| Name of Person Being Referred |  | |
| Date of Birth |  | |
| Address |  | |
| Contact Phone Number and Email of Person Being Referred | **Phone** | **Email** |
| Name of Referrer |  | |
| Referrer Contact Number and Email | **Phone** | **Email** |
| Name of emergency contact and relationship to person referred |  | |
| Phone/email address for emergency contact | **Phone** | **Email** |
| Consent from emergency contact to share details | **Yes** | **No** |
| GP Details | **Name/ Practice** | **Phone Number** |

|  |  |
| --- | --- |
| How is the person’s mobility?  Do they use any mobility aids, if so, what?  Would they need any additional support if going out? |  |
| How is the person’s sight and hearing? Do they use any aids, if so, what?  Would they need any additional support to engage with a befriender? |  |
| Are there other illnesses or long- term conditions which we might need to know about? If so, what?  **Please note we cannot accept referrals with a diagnosis of dementia.** |  |
| Does the person have any language or cognitive barriers which could affect engagement with a befriender? If so, please describe these. |  |

|  |  |
| --- | --- |
| Please give details of any allergies. |  |
| Please tell us a bit about why you would like a befriender. |  |
| Are you currently getting support from anywhere else? Please describe any existing support (This might be physical or mental health support, help with personal care, practical support like shopping) |  |
| Please tell us a bit about things you enjoy doing (hobbies, interests, activities etc) |  |

**Referrer Print Name: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrer Signature:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**

**Consent Form**

|  |  |  |
| --- | --- | --- |
| **Item** | **Consent Given** | **Consent Refused** |
| MKHH can securely hold my information in paper and electronic form during the referral process |  |  |
| MKHH can contact me for more information about my referral |  |  |
| MKHH can contact my emergency contact about more information on my referral |  |  |
| MKHH can share my information, only if I am being signposted to another organisation |  |  |

Signed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_