Member Referral

Which of the following befriending services are you requesting?

Befriending for older people

Befriending for older people living with dementia

Befriending for older people with mental health problems

Is this a self-referral or third party referral? If self-referral, please ignore the first two boxes and go straight to **'member details'**
If third party referral - is member aware of the third party referral? If **'NO'**, please ensure permission is obtained from the member before proceeding.
Referrer Details Name: Organisation or relationship with Member: Tel No: Email:
Member Details Title: Surname: First Name: Known as: Age: Date of birth: Address: Postcode: Tel No:
Where was the service advertised?
Additional Information: Details of current home situation: i.e. living alone? Details of any professional care in place: Details of any existing regular social engagement inside or outside of the home: Details of any pets: Does anyone in the house smoke?

Additional Information continued: Please give any further relevant supporting information regarding this referral (e.g. dealing with life changes, loss of family connections, recently moved home, recent return from hospital,). Please provide as much information as possible:
GP Practice name: GP Practice address and post code:
This question must be asked to the Member: **The West Kent Befriending Service operates a zero tolerance policy against all discrimination including age, disability, nationality, race religion or sexuality.** **Are you happy to proceed?**
Office Use Only: *Date referral received:* *Date referred to manager:* *Any additional information:*