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Befriending / Home Visiting Scheme – Referral Form

Date of referral: .....

Name, & Address of Service User (i.e. deaf person):

.....

.....

Date of Birth: .....

Is the service user Male or Female? .....

Name, Address & contact details of person making the referral

.....

.....

Relationship to client: .....

If possible, please detail what kind of support the Deaf person would benefit from (i.e. letter reading, company, support accessing Deaf club etc)

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At what location / address will the befriending / visiting take place? (i.e. within the clients home, a care-home, within the community (i.e. coffee shop, deaf club etc)

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When would be the preferred day / time for the befriending to take place? (i.e. during the daytime / evening / Wednesdays only etc):

.....

Name of a family member / emergency contact for service user:

.....

Further Information regarding the service user:

Is the client: Deaf / Hard of Hearing / Deafened / Deaf-blind **(please circle)**

What is the preferred communication of the client: (i.e. BSL, Lipreading, Spoken English)?

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Does the client have any additional needs or disabilities (language, mobility, communication)?

.....

Is there any medical information we need to be aware of?

.....

Does the client have any Mental Health issues? YES/NO **(PLEASE CIRCLE)**

Would the client prefer a male or female volunteer (please state)?

.....

Is there a preferred time and day the service user would prefer for a volunteer to visit?

FOR OFFICE USE:

BSL / Communication skills required from volunteer –

Any other skills needed for role? (i.e. guidance, visual impairment awareness)

Name of delegated volunteer/s - .....