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| Kincardine  & Deeside  Befriending | 8 Robert Street, Stonehaven, AB39 2DN    **Tel (01569) 765714**  **Email: info@kdbefriending.org.uk**  **Website: www.kdbefriending.org.uk** |

# REQUEST FOR VOLUNTEER BEFRIENDER (CONFIDENTIAL)

**Please complete this form electronically or by hand (clearly and using black ink) and return to K&DB as detailed above.**

**The Coordinator will visit the client in order to discuss the service with them.**

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| **Is this referral with the consent of the client?** | **YES / NO**  **(please delete as appropriate)** |

**The ongoing involvement of referrers is valued and will include supplying updated information regarding a client and participation in our assessment process**

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| **Name of client:** | **Title**: |
| **Date of birth**: | |
| **Address:**  **Postcode**: | |
| **Telephone (home**):  **Mobile telephone**:  **Email address**:  **Is there another person of whom we should be aware e.g. with Power of Attorney, Carer etc? If so, please give details (name, relationship, contact details etc)** | |

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| **Name of referrer:** | **Title**: |
| **Job title**: | |
| **Address:**  **Postcode**: | |
| **Telephone (office**):  **Mobile telephone**:  **Email address**:  **Contact availability:** | |

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| **Description of clients’ situation (please include all relevant background information, and** **any health issues):** |
| **What other services are provided for the client at present?** |
| **What services are being sought for the future?** |

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| **What role do you envisage for a volunteer befriender?** | | |
| **Identified Need** | **Y / N** | **Cause/How a befriender might benefit this client** |
| **Reduce isolation** |  |  |
| **Improve social contact** |  |  |
| **Improve self confidence** |  |  |
| **Improve self-esteem** |  |  |
| **Improve access to other services** |  |  |
| **Improve ability to get out of house** |  |  |
| **Improve mood/depression** |  |  |
| **Support for carer** |  |  |
| **Contribute to ability to live in own home for longer** |  |  |
| **Other (please describe** |  |  |

|  |
| --- |
| **Date of referral**: |

**Thank you for completing this form. We will contact you to let you know if we are able to accept the referral and to keep you informed of progress.**