**Referral Form for**

**Home Visitation Service,**

**Friendly Call and Social Clubs**

The aim of our visitation service is to provide isolated older people with a suitable volunteer in the hope that a close and sincere friendship may develop. We also offer a Friendly Call Service to all our older friends whereby each week they will receive a phone call to check in with them and see how their week has been.

Please note that our volunteer’s role is purely a social one. They are not unpaid carers. They will not provide any intimate or personal care. They will not assist with any medication.

The visitation service is **not suitable** for anyone who wants help with household chores, physical care, respite care, a sitting service or carer relief, shopping, banking or DIY. The standard age for our visitation programme is **70** although this age is not absolute. Our visitation service is **only** available for older people throughout the **Dublin region**. Our Friendly Call Service is **nationwide.** All trips and social clubs will originate from our hall at 25 Bolton Street Dublin 1. Please note that all referrals will be subject to adherence with our guidelines and criteria for the visitation service. These can be found on our website www.friendsoftheelderly.ie

All referrals should be sent to info@friendsoftheelderly.ie or 25 Bolton Street Dublin 1

**Details of the Older Person**

|  |  |
| --- | --- |
| **Date of referral:** Click here to enter a date. |  |
| **Name:** | Click here to enter text. | Click here to enter text. |
|  | First name | Surname |
| **Address:** | Click here to enter text. | Click here to enter text. |
|  | Number and street | Area |
|  | Click here to enter text. |  |
|  | Post code |  |
| **Phone numbers:** | Click here to enter text. | Click here to enter text. |
|  | Home phone | Mobile |
| **Date of birth:**  | Click here to enter a date. |  |
|  | Date / Month / Year |  |

Please fill in the details that you are aware of in the older person’s daily schedule, i.e. when friends or relatives visit, when home help comes, when they go to an activity, etc…

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Morning [ ]  | Morning [ ]  | Morning [ ]  | Morning [ ]  | Morning [ ]  | Morning [ ]  | Morning [ ]  |
| Afternoon [ ]  | Afternoon [ ]  | Afternoon [ ]  | Afternoon [ ]  | Afternoon [ ]  | Afternoon [ ]  | Afternoon [ ]  |
| Evening [ ]  | Evening [ ]  | Evening [ ]  | Evening [ ]  | Evening [ ]  | Evening [ ]  | Evening [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| **First name** |  | **Surname** | **Relationship** |
| Click here to enter text. |  | Click here to enter text. Click here to enter text. |
|  **Phone number** |  | **Address** |
| **E-mail** Click here to enter text. |  |  |

**Physical Health of the Older Person**

**Next of Kin**

Please give details of all pertinent physical health conditions relating to the older person e.g. previous medical procedures, mobility issues, current physical conditions

Click here to enter text.

**Mental Health of the Older Person**

Please give detail of all pertinent mental health conditions relating to the elderly person e.g. dementia, Alzheimer’s disease, anxiety, cognitive impairment

Click here to enter text.

**Further Details about the Older Person**

Please tick the box for the relevant living situation of the older person and please state any supports currently in place e.g. Day Centre or Social Club Click here to enter text.

Lives Alone [ ]  Visited by volunteer from another agency [ ]

Lives with family member(s) [ ]  Please give details Click here to enter text.

Lives with non-family member [ ]  Please give details Click here to enter text.

Visited by family/friends: Everyday [ ]  At least once a week [ ]  Less than once a week [ ]

Please state your reason for this referral: Click here to enter text.

**Programmes required**

Is this older person open to receiving a visitor in their home? **YES** [ ]  **NO** [ ]

Any information relevant to visiting this older person:

Click here to enter text.

Other Service Required Friendly Call [ ]  Social Clubs [ ]

Is this older person also interested in any of our other activities **YES** [ ]  **NO** [ ] (Christmas Parties, Day Trips, Afternoon Lunches etc.)?

Click or tap here to enter text.

**Consent/ Authorisation**

I give my consent that the information given on this form can be passed on to Friends of the Elderly Ireland.

I am aware that the service is completely free and that I can ask for the service to cease at any time I chose.

I understand that this service is run on a voluntary basis and that Friends of the Elderly are under no statutory responsibility or legal obligation to provide the service

Signed: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referrer Information -** *Please note if this info is not fully completed there may be a delay in processing*

**Name:** Click here to enter text. **Surname:** Click here to enter text.

**Address:** Click here to enter text.

**Work phone:** Click here to enter text. **Mobile:** Click here to enter text.

**E-mail:** Click here to enter text.

**Relationship to the older person:** Click here to enter text.

**Data Protection** - **How we use your information**

Thank you for completing this form. The data provided will be used by Friends of the Elderly for the purposes of supporting the client. We shall use the information supplied in line with Data Protection Guidelines. Information held by Friends of the Elderly is strictly confidential and we do not share information or pass on any of our member’s personal data to organisations and/ or individuals without their consent.

**Please return the completed Referral Form to;**

**Friends of the Elderly Older Persons Services**

**25 Bolton Street, Dublin 1**

**Please mark your envelope PRIVATE AND CONFIDENTIAL.**

**Or email it to** **info@friendsoftheelderly.ie**

**For Office Use only:**

**Date referral received …………………………………………………………**

**Referral accepted: YES / NO**