**Home Services Referral Form**

**Personal Details**

|  |  |
| --- | --- |
| Name:  |  |
| Address: |  |
| Tel: |  |
| Mobile: |  |
| Email: |  |
| D.O.B: |  |
| Ethnicity: |  |
| Emergency Contact details (if available):  |  |
| Registration | Sight Impaired (PS)Severely Sight Impaired (B)Not RegisteredUnknown |
| Blue Badge Holder | Yes No |
| Details of hearing loss (if any):  |  |
| Other Health Conditions (if any):  |  |
| Does client use walking aids outside the house? If “yes, what kind? | Yes No |
|  |
| **Please Note: Unfortunately, we are unable to accept referrals for wheelchair users for any home services which take place outside of client’s home e.g. shopping, going for coffee etc.**  |
| Does client have difficulties understanding speech and/or simple instructions? If yes, please explain. | Yes No |
|  |
| Does the client have any memory problems? If yes, please explain. | Yes No |
|  |
| **Please Note: Unfortunately, we are unable to support referrals for clients who have been diagnosed with, or are suspected of having, any form of dementia.** |
| Can the client manage their own personal care? | Yes No |
| **NB: Our volunteers cannot provide any form of personal care.** |
| Can the client get in and out of a car independently? | Yes No |
| Any dietary requirements?If yes please give details | Yes No |
|  |

**Service Requirements**

What support, provided by our Home Services, does the client require?

|  |
| --- |
| **Befriending** |
| Visits at home for conversation  |  |
| Outings to cafes etc |  |
| Short walks |  |
| **Reading** |
| Help with correspondence |  |
| Being read to from books/papers/magazines etc. |  |
| **Shopping** |
| Being taken food shopping |  |
| Being taken clothes shopping |  |
| Being taken shopping for gifts |  |
| Being taken shopping for anything else (please specify below) |  |
|  |
| Any other activity not listed (please specify):  |  |
|  |
| **Please note: BucksVision may be able to accommodate other activities, however this would be reviewed on a case by case basis and is dependent on the type of activity and volunteer availability.** |
| **What are the client’s hobbies and interests, e.g. cooking, gardening, craft etc?** This helps with matching clients and volunteers. |
|  |

**Information about residence**

|  |  |
| --- | --- |
| **Is anyone else likely to be present in the home while the volunteer is visiting?**If yes please indicate who | YesNo |
|  |
| **What type of home does the client live in?** |
| House |  |
| Flat (on which floor) |  |
| Maisonette (on which floor) |  |
| Bungalow |  |
| Other  |  |
| **Is there a lift?** | YesNoN/A |
| **Does the client smoke?** | YesNo |
| **Does the client have a guide dog/assistance dog?** | YesNo |
| **Does the client have any pets?**If yes please list what pets | YesNo |
|  |

**Newsletter**

|  |  |
| --- | --- |
| **Would client like to receive our quarterly newsletter?**If yes in which format: Email, Large Print, Audio | YesNo |
|  |

**Final Information and Consent**

|  |
| --- |
| Is there any other information we need to know or that the referrer/client wishes to tell us? |
|  |

|  |  |
| --- | --- |
| Has the client given consent for this referral and for their information to be retained by our charity for as long as they require our services. | YesNo |

**Referrer Details**

|  |  |
| --- | --- |
| Referred by |  |
| Name |  |
| Organisation/Relationship to client  |  |
| Phone  |  |
| Email |  |

Once completed please return to Lisa Redford, Home Services Co-ordinator:

Email: lredford@bucksvision.co.uk

Post: 143 Meadowcroft, Aylesbury, HP19 9HH

Phone: 01296 487556