 **HAND OF SOLACE**

 *Giving a hand of support and empowerment*

  **Charity No. SC048192**

**Young People Befriending Service Referral Form**

**Please note that all information supplied will be treated as confidential**

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| --- |
| Name of Young person:   |
| Address:   Tel no:  |
| Email Address  |
| GP Address  Tel no:  |
| Please tell us anything about the young person’s current health and wellbeing situation:   |
| Young Person’s current network of support i.e. community nurse, family member etc. which you feel may be relevant:   |
| Referee’s date of birth; |
| What do you hope the Befriending Service involvement will achieve? ***Please tick the top three that most apply****:*  |
| Reduced feelings of Isolation:  |   |
| Reduced feelings of anxiety:  |   |
| Improved levels of wellbeing:  |   |
| Improved levels of self-esteem/confidence:  |   |
| Improved quality of life:  |   |
| Increased independence:  |   |
| Increased social links:  |   |
| Reconnection with family  |   |
| Assistance with a personal goal:  |   |

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| Please give details of anyone we can contact in case of concern (Relative, friend, neighbour or social worker). Please supply name, email address, postal address and telephone number:      |
| Is there anything else we should know?    |
| Signed:    | Date:  |
| *If this form is been completed by a family member or Health or Social Care Professional please supply the following details:* ***(please note that incomplete forms will be returned to referrer)***  |
| Name of Referrer:   |
| Relationship to young person:   |
| Address of Referrer:   |
| Contact Number of Referrer:   |
| Email address of Referrer:   |
| Please state whether in your opinion it is safe for the young person referred to be taken out of their home on escorted visits Yes or No?  |
| Have you carried out a risk assessment for this young person? (to be completed by a Health or Social Care Professional) Yes □ No □ If yes – please attach to this form |
| Do you or anyone else apart from family member want to be present on an assessment visit? Yes □ No □ If yes, please supply contact details:   |
| **Please remember that we will not accept referrals unless permission to refer and to pass on information has been given by the young person you are referring.** Does this young person know that they are being referred? Yes □ No □ |
| Referrer signature:   |
| Date:   |

 **Please return form to:**

**11 Goodhope Garden**

**AB21 9NG , Aberdeen**

 ***Telephone: 07378432436***

 ***or***

 ***Info@handofsolace.co.uk***

**Risk Assessment**

|  |  |  |
| --- | --- | --- |
|  Does the young person have any criminal convictions?   |  Yes  |  No  |
| If yes, please provide details of conviction    |
|  Areas of risk to self (if there is a known risk to self, please give full details)    |
|  Areas of risk to others (if there is a known risk to others please give full details)      |
|  Additional Information (is there other relevant information or areas of concern that we need to be aware of eg unusual or aggressive behaviour?)       |