 **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**

|  |  |
| --- | --- |
| 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: |  |

|  |  |
| --- | --- |
| 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?) | | |