**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 Registered  Unknown | | | | |
| 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 | Yes  No |
|  | |
| **What type of home does the client live in?** | |
| House |  |
| Flat (on which floor) |  |
| Maisonette (on which floor) |  |
| Bungalow |  |
| Other |  |
| **Is there a lift?** | Yes  No  N/A |
| **Does the client smoke?** | Yes  No |
| **Does the client have a guide dog/assistance dog?** | Yes  No |
| **Does the client have any pets?**  If yes please list what pets | Yes  No |
|  | |

**Newsletter**

|  |  |
| --- | --- |
| **Would client like to receive our quarterly newsletter?**  If yes in which format: Email, Large Print, Audio | Yes  No |
|  | |

**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. | Yes  No |

**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](mailto:lredford@bucksvision.co.uk)

Post: 143 Meadowcroft, Aylesbury, HP19 9HH

Phone: 01296 487556