**Client Referral & Assessment Form**

|  |  |
| --- | --- |
| Macmillan Nurse |  Friend/family/carer |
|  Self |  Other (Please specify) |
| Date of Referral |  | Assessment Date (office use only)  |
| Name of referrer |  |
| Address of organisation |  |
| Telephone number |  |
| Email |  |
| Is client/family aware of referral? |  |

**Client Details**

|  |  |
| --- | --- |
| Client name |  |
| Telephone number | Landline |  | Mobile  |  |
| Email address  |  |
| Address line 1 |  |
| Address line 2 |  |
| Town  |  |
| County  |  |
| Postcode  |  |
| Date of Birth |  |
| Gender  |  Male |  Female  |  Transgender  |
| Ethnicity | Please State:  |
| Disabled?Blue Badge | Disability type (state which):  Blue Badge holder  |
| Religion or Belief |  No Religion  | Faith (state which):  |
| Employment Status |  Retired |  Employed |  Unemployed | Other |
| Relationship Status |  Single |  Married |  Civil Partnership |  Cohabiting |
|  |  Widowed |  Divorced |  |  |
| Sexuality | Heterosexual |  Lesbian |  Gay  |  Bisexual |

**Client Emergency Contact/NOK Details/Carer’s details**

|  |  |
| --- | --- |
| Name |  |
| Telephone number |  |
| Relationship to Client |  |

**Client’s GP Details**

|  |  |
| --- | --- |
| GP Name |  |
| Telephone number |  |
| GP Practice Address  |  |

**Client’s Medical History**

|  |
| --- |
| Brief medical information, e.g. Diagnosis, Treatment Plan, Medication, Physical and emotional state, Mobility and degree of dependency on carer: |

**Diagnosis/Prognosis**

|  |
| --- |
| What does the client understand about the a) diagnosis b) prognosis? |

|  |  |  |
| --- | --- | --- |
| Are all other members of the family aware of the client’s condition? |  Yes |  No |
| Is any other agency providing services? (If Yes please specify) |  Yes |  No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What would the client like support with? |  Home Support |  Transport |  Social group |  Telephone befriending |
| Additional information: |
| Home Support(Preferred times for visits) |  Weekdays daytime  | Anytime |  |

|  |
| --- |
| Does the client need a volunteer of a specific gender? (Please only specify if this would impact on the relationship) |
|  No preference  |  Male  |   Female  |
|  |  |  |

|  |
| --- |
| **Referrer Additional Comments** (Please include health & safety, safeguarding, transport/access issues if appropriate) |
|  |
| **Being There collects personal information in order to provide the right support service and volunteers for your need. Data is kept on a password protected, secure database. We keep your data on record until the nearest financial year end to when you stopped using our service. We do this in order to collate anonymous annual statistics for service monitoring purposes. If our services are not appropriate to your needs we may refer you to another organisation such as a charity or the NHS. Your consent would be required in order to do this. We also share your basic contact details with the volunteer that is agreed to provide support to you. You can request to see what data we hold on you at any time. We will provide the data within two weeks of request as a printed document sent to your home address.****I consent to Being There processing my personal details.****Signed:****Print Name:****Date:** |
| Office Use onlyCare PlanAssessment Visit Date: Volunteer Placed Date (Home Support): Placement Details:  |

|  |
| --- |
| **Instructions for submitting referral:** |
| **Being There:-** Send as an e-mail attachment to tameside@beingthere.org.uk or telephone referral: 0161 217 1373 or post to:Being There Tameside & GlossopTameside Centre for EnterpriseOld StreetAshton-Under-LyneOL6 7SF |