

Confidential Client Introduction Form

Name of person who needs help:

Hospital Homecoming

Please tick if this referral is for our **hospital homecoming project** (*short term help for people recently discharged from hospital*).

If help is requested to start within 5 days please call our office on 023 8021 6023 or put 'homecoming referral' as the subject of your email. Our help is dependent on a volunteer being available.

**If you have any questions or would like help completing this form please call our office on:
023 8021 6016**

We are a local charity who aim to match volunteers with people who need help in Southampton. Our 'Communiters' are kind-hearted volunteers who want to help reduce loneliness and isolation within our city. They are not trained support workers and their help is limited to the sort of help a good neighbour might be reasonably expected to give.

Please see our 'notes for referrers' or call our office for more information. Unfortunately we do have a long waiting list in many areas.

1

| | | | |
|--------------------------------------|--|-------|--|
| Name of person completing this form: | | Date: | |
|--------------------------------------|--|-------|--|

- If you are completing this form for yourself (you want our help) please complete sections 2, 4 and 5.
- If you are completing this form on behalf of someone else (you are a referrer) please complete sections 3, 4 and 5.

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| I am completing the form for myself | | | |
|-------------------------------------|------------|-----------|---------------|
| Title | First name | Last name | Date of birth |
| Postal Address (including postcode) | | Landline | |
| | | Mobile | |
| | | Email | |

Communicare will look after information about you securely and only use it to run our organisation. We will not pass on your details to other organisations without your permission unless we have reason to believe you may be injured or at risk of harm in which case we may contact medical services or social services. Full details are in our privacy policy and data retention policies which are available on our website or from our office.

Now go to section 4

3

I am referring someone else. Your (the referrer's) contact details

Please return to **Communicare in Southampton, Voluntary Action Centre, Kingsland Square, Southampton, SO14 1NW** or email to referral@communicareinsouthampton.org.uk

Communicare in Southampton Confidential Referral Form

| | | | |
|-------------------|------------------|--|--|
| First Name | Last name | Position and Organisation or relationship to client | |
| Landline | | Mobile | |
| Email | | I confirm that the client has given me permission to pass on their details: | |

Communicare will store your (Referrer's) information with this referral. We will only use it to contact you about this referral and won't pass on your details to any other organisation. Full details are in our privacy policy and data retention policies which are available on our website or from our office.

Details about the client

| | | | |
|--|-------------------|------------------|----------------------|
| Title | First name | Last name | Date of birth |
| Postal Address (including postcode) | | Landline | |
| | | Mobile | |
| | | Email | |

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Please give details about your, or the person you are referring's, needs.

| | | | | |
|--|----------|---------------------|-------------------------------|---------------------|
| Disadvantages Faced <i>Please highlight each disadvantage</i> | Medical | Social isolation | Physical disability | Mental health issue |
| | Dementia | Learning difficulty | Sensory loss | Other |
| Why is help needed from Communicare? | | | | |
| Is there any support already in place? <i>Include family/friends /other agencies and any personal care providers</i> | | | | |
| Any other information? | | | | |
| Please list any pets: | | | | |
| Please state any walking aid(s): | | | Does the client smoke? | |
| Next of kin/emergency contact: | | | | |

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Our volunteers are kind-hearted ‘good neighbours’ and not trained support workers or councillors. Please answer the following ‘risk assessment’ questions to help us protect volunteers and the people we help from possible harm. If the answer to any of these questions is ‘yes’ we will contact you for further information to determine whether or not our volunteers may be able to help.

| | | | |
|--|----|-----|--------|
| Does the person referred have a history of violent, aggressive or unpredictable behaviour towards others? (Including verbally aggressive behaviour). | No | Yes | Unsure |
| Does the person referred have a history of violence towards themselves e.g self-harm, suicidal thoughts or is considered to be at risk of suicide attempts? | No | Yes | Unsure |
| Additional information? | | | |

| | |
|---|--|
| What sort of help is required? <i>Highlight all that are applicable and indicate a priority if multiple requests.</i> | |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Befriending (visiting at home) |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Family Support |
| <input type="checkbox"/> Accompanying on walks or outings | <input type="checkbox"/> Social Activities (incl. lunch club & tea parties) |
| <input type="checkbox"/> Gardening, DIY or decorating | <input type="checkbox"/> Help with correspondence or administration |
| <input type="checkbox"/> Hospital Homecoming | <input type="checkbox"/> Other: please explain below |
| Please give brief details of help requested | |
| If transport is requested please complete the following <i>Clients must be able to get in and out of a car with minimal help. We do not have adapted vehicles.</i> | |
| <input type="checkbox"/> Client needs front seat | <input type="checkbox"/> Client can get into back seat of a car with 4 doors |
| <input type="checkbox"/> Client can get into back seat of a 3 door car | |
| If walking aids need to be taken please state what and if walkers or wheelchairs whether they fold | |
| Details of any booked appointments or groups client would like help to attend (including date and time) | |

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Now please complete the ethnicity and diversity monitoring form on the next page then return this document to the address at the bottom of the page.

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ETHNICITY & DIVERSITY MONITORING

Many of our funders are interested in the range of backgrounds of our **clients**. By completing this form you will be helping us to provide this and secure further funding

This information will be only used for anonymised monitoring purposes.

| Please complete this for the person who would like our help (yourself or the client if you are their referrer) | | | | | |
|--|--|----------------|--|---------|--|
| Age: | | Date of Birth: | | Gender: | |
| What is their ethnic group? Choose one section from (a) to (e) and tick the appropriate box to indicate your cultural background | | | | | |
| (a) White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background <i>please write in below</i> | | | (b) Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background <i>please write in below</i> | | |
| (c) Asian or Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background <i>please write in below</i> | | | (d) Mixed <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other Mixed background <i>please write in below</i> | | |
| (e) Other ethnic group <i>please write in below</i> | | | | | |

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