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| **ELFT Befriending Service Referral**  |
| Please complete this referral form and return via email to:elft.befriendingservice@nhs.net  |
| Service User information |
| Full Name:  |
| D.O.B:  |
| Address:  |
| Contact Number:  | Email:  |
| Description of why the Service User is being referred: E.G., lonely, hasn’t many friends or family, would like to have social contact with someone.  |
| How long will the Service User require the service?3 Months [ ]  6 Months [ ]  |
| Has the Service User been referred to this service previously?Yes [ ]  No [ ]  |
| Has Service User given consent?Yes [ ]  No [ ]  |
| Does the Service User require any reasonable adjustments for them to access the service? Yes [ ]  No [ ] Please state: |
| details OF RESPONIBLE clinician (this can be a gp if Service User is in primary care) |
| **All referrals must include the name and email of a Responsible Clinician, who we can highlight any instances of specific clinical concern to. The referral may not be accepted if this information is not provided. (This can be a GP if the Service User is in Primary Care/Community Health)**  |
| Responsible Clinician Name:  | Team/Practice:  |
|  | Email:  |
| details OF referrer |
| Referrer Name:  | Team:  |
| Contact Number:  | Email:  |
| Signature:   | Date: |