VISITING SERVICE for North of Scotland (part of Friendship Services) Charity No. SC039555

CLIENT REFERRAL FORM – Strictly Confidential

PART A – CLIENT

NAME ____ Mr/Mrs/Miss/Ms)

Address *(incl postcode)* ____

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Date of Birth ____________________ Client Tel. No. ____________________

Name/Tel. No of any main contact for Client ____________________

Name/Tel. No. of Next of Kin ____________________

Does the Client live alone? Yes / No *(if No, provide details)* ____________________

Is Client housebound? Yes / No / Virtually ____________________

Reason for being housebound? ____________________

General health of Client? ____________________

Is Client impaired? Hearing – Yes / No Visually - Yes / No

Does client smoke? Yes / No

Previous occupation ____________________

Interests and hobbies ____________________

Interested in pets? Yes / No

Any Church connection? ____________________

Family involvement (when, how often) ____________________

Visits from friends/neighbours? ____________________

Social care / home help / other support ____________________

Medical practice *(Doctor name, Tel. No.)* ____________________

***PART B* – Name of person referring** ____________________

(Relative / Health professional / neighbour / self)

Tel No. of person referring ____________________

Reason for referral ____________________

Date of referral ____________________

Please return this form to: The Visiting Service for North of Scotland, PO Box 5743, Inverness IV1 9DN