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| **ELFT Befriending Service Referral** | |
| Please complete this referral form and return via email to:[elft.befriendingservice@nhs.net](mailto: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: |