**ACE Neighbours Referral / Application Form**

Please read the ACE Neighbours Referral Criteria carefully before completing this form. This form can be completed by:

* A referrer (such as a relative, friend or health & social care professional).
* An individual wishing to refer themselves to the project.

Please be aware that St Monica Trust will file this information securely. It will only be shared with the relevant people working on the project.

Please complete all sections of the form. If you need any help with filling it in please call Catherine on 07817 632 963 or 0117 305 2365, Mondays to Wednesdays. **Please complete in BLOCK CAPITALS.**

|  |  |  |
| --- | --- | --- |
| **PERSONAL DETAILS** | | |
| **Title** | **First name** | **Last name** |
| **What do you / they prefer to be called?** |  | |
| **Address** |  | |
| **Postcode** |  | |
| **Telephone no.** | **Home** | **Mobile** (if you have one) |
| **Email address**  (if you have one) |  | |
| **Date of birth** |  | |

|  |
| --- |
| **REFERRAL CRITERIA** |
| Please tick the box to confirm you / the referred person can walk unaided  (or with a walking stick or frame) for at least 300 metres. |

|  |  |  |
| --- | --- | --- |
| **DETAILS OF REFERRER (IF NOT THE PERSON OVERLEAF)** | | |
| **Title** | **First name** | **Last name** |
| **Relationship to the person being referred** |  | |
| **Job title and organisation name (if applicable)** |  | |
| **Address** |  | |
| **Postcode** |  | |
| **Telephone no.** | **Landline** | **Mobile** (if you have one) |
| **Email address** |  | |
| **Consent** | Please tick the box to confirm that you have gained consent from the person to make this referral and share this information | |

|  |  |
| --- | --- |
| **REFERRAL REASON** | |
| What are the reasons for wishing to participate in ACE Neighbours? |  |

|  |  |
| --- | --- |
| **INTERESTS** | |
| So we can match our participants with our volunteers it would be useful to have an idea of interests and the kinds of things done in spare time. Feel free to tell us about things done in the past as well as things enjoyed now. |  |

|  |  |
| --- | --- |
| **GP DETAILS** | |
| GP name |  |
| Practice name |  |

|  |  |
| --- | --- |
| **PERSONAL CIRCUMSTANCES** | |
| Please give details of any physical or emotional issues (e.g. arthritis in hands, communication difficulties, nervous of falling, recently bereaved, anxious) |  |
| Do you / the referred person live alone?  If **No**, please state who else lives in the house | Yes / No |

|  |  |
| --- | --- |
| **OTHER SUPPORT** | |
| Please give details of any help given by other services / family  (e.g. weekly visit from community nurse / children / grandchildren / neighbour) |  |

|  |  |  |
| --- | --- | --- |
| **HOW DID YOU HEAR ABOUT ACE NEIGHBOURS?** | | |
| Word of mouth | Who did you hear about ACE from? i.e. friend, walk leader |  |
| Posters/leaflets | Where did you see the leaflet/poster? |  |
| Other | Please give details |  |

**Please return this form, marked CONFIDENTIAL to:**

Catherine Robinson, St Monica Trust, Monica Wills House, Cromwell Street, Bristol, BS3 3NH

or via email to:

[catherine.robinson@stmonicatrust.org.uk](mailto:catherine.robinson@stmonicatrust.org.uk)

**………………………………………………………………………………………….**

**OFFICE USE: to be completed once participant joins the project**

|  |  |  |
| --- | --- | --- |
| **EMERGENCY CONTACT FOR PARTICIPANT** | | |
| **Title** | **First name** | **Last name** |
| **Address** |  | |
| **Post code** |  | |
| **Telephone no.** | **Home** | **Mobile** |
| **Relationship to participant** |  | |

|  |  |
| --- | --- |
| **AVAILABILITY** | |
| Are there any unsuitable days and times for visits? |  |