Referred by:	or Self Referral
Name:	Position:
Tel:	Email:
Organisation:	Consent to share: Verbal / Written
Referral Reason:	

Referral details Date:		NHS Number:			
Client Title:		**Client Name:** (or known as)			
Address:					
Email Address:					
Postcode:		Tel:			
DOB:		Age:	M / F		
Lives Alone	Y / N	Smoker	Y / N	Hazards	Y / N*
Pets:		*if Y - describe hazards			
Armed Forces Vet / Spouse?		Y / N state which branch			
Emergency Services Caller?		Y / N			

Known Health Conditions or Disabilities?					
Mental Health…	Cardiac		Cancer		Hip/ Knee
	Stroke		Epilepsy		Confusion
	Diabetes		Allergies	Other	

Physical mobility						
Mobile	Mobile with assistance	Stick/s	Crutches	Frame	Wheelchair	Other

Sensory Ability and Aids			
Pendant Alarm:	Sight:	Speech:	Hearing:

Medication: Prescribed Over Counter			
Any medication?	Y / N	Clear understanding of current treatment	Y / N*
*if N – refer to Pharmacist / GP? (consent required)			

General Practitioner		
Name:	Practice:	Tel No:

Next of Kin – emergency contact	
Name:	Relationship:
Address:	
Postcode:	Tel:
NoK email address:	

Key Holder and Key Safe details		
Name:		Tel:
Address:		
Email address:		Key Safe Number:

Age UK Portsmouth Tel: 023 9288 3522 Email:Close.Encounters@ageukportsmouth.org.uk
Gosport Voluntary Action Tel: 023 9250 3871 Email: homeserveadmin@gva.org.uk

Further Information	
Where did you hear about Close Encounters:	
What type of Service is required:	
How would the referred like to be contacted:	
Is the referred a homeowner:	

Additional Notes Relevant to Referral:

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