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| **Norfolk Deaf Association****Befriending Service Referral** |  |

The information provided on this form helps us match the Befriending Service more precisely to the service user’s needs and is held in the strictest confidence by the NDA. Please complete the application and return it by post or by email to:

14 Meridian Way
Meridian Business Park
Norwich
NR7 0TA

Phone: 01603 404440
Fax: 01603 404433

Email: befriending@norfolkdeaf.org.uk

**Date**..................................................................

**Client Details**

Name ........................................................................................................................

Address ......................................................................................................................

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Date of Birth……………………………………………………………………………..

Phone Number....................................... Mobile ..............................................

Fax ..........................................................................................

Email ............................................................................................................................

Preferred method of contact ..................................................................................

**Level of Hearing Loss**Hard of Hearing **[ ]** Profound hearing loss **[ ]** BSL user **Yes** / **No**Additional needs (e.g. physical disability, mental health issues)

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**Referrer Details**

Referring Agency….................................................................................................................

Contact Name …....................................................................................................................

Position …..............................................................................................................................

Phone Number….....................................................Fax........................................................

Email ….................................................................................................................................

**Reason for referral**

*(To help us with our assessment please provide any supporting information)*

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**Other factors to be aware of** *(e.g. client living alone, other professionals involved)*

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