Compassionate Neighbours is free, community-led support for people who are lonely and/or socially isolated and are nearing the end of life through age or illness.

It is delivered by St Joseph’s Hospice in Hackney and Tower Hamlets

*“Compassionate Neighbours changes people’s lives. Long may the project continue to grow, its roots dig deep and become the lifeline it is, for all. You cannot put monetary value on this project, if I had to, I would say there is not enough money in the world it is priceless*.”

**All sections of this form need to be completed and emailed to** [**CN@stjh.org.uk**](mailto:CN@stjh.org.uk)

We aim to support people that need emotional and or social support and our inclusion criteria below will help you decide if this project is the right one for this person.

**Before making this referral please check this person meets the following:-**

**3 out of the 5 inclusion criteria below**

**Please check appropriate box/es below:**

|  |  |
| --- | --- |
| **Inclusion Criteria**  Isolated/lonely  Nearing end of life/terminal illness  Elderly (75+)  Frail  One or more debilitating/long term health conditions | **Exclusion Criteria**  Advanced dementia (Please refer to Namaste Care)  Unmanaged substance misuse  Unmanaged mental health issues |

**Please tell us in summary why you are making this referral.(e.g. social or emotional support)**

**Referrers Details**

|  |  |  |
| --- | --- | --- |
| Date | Click or tap to enter a date. | |
| Your Full Name | Click or tap here to enter text. | |
| Job Title/Role/Relationship | Click or tap here to enter text. | |
| Type of Referral | Choose an item. | |
| Organisation/Other |  | |
| Telephone number |  | |
| Email address |  | |
| Would you like to be informed of the outcome of this referral | | **Yes  No** |

**Details of the person you are referring**

|  |  |  |
| --- | --- | --- |
| Full Name | Click or tap here to enter text. | |
| Home or mobile telephone number |  | |
| Address |  | |
| Post code |  | |
| Borough | Choose an item. | |
| Date of Birth | Click or tap to enter a date. | |
| Ethnicity |  | |
| Preferred language | Choose an item. | |
| Other Language/s |  | |
| Will a translator be required for a home visit? | | **Yes  No** |
| Has the person agreed to be referred to this project? | | **Yes  No** |
| Is the person willing to be contacted by phone? | | **Yes  No** |

|  |  |
| --- | --- |
| Is this person being supported by any other service at St Joseph’s Hospice **If yes please indicate which one/s** | **Bereavement/Counselling  Day Hospice**  **ELT  Namaste  Carers Service**  **Dietician  Art therapy**  **Social Work/Welfare Services**  **SALT (Speech and Language Therapy)**  **Complementary Therapy  Accelerate**  **Physiotherapist/Occupational Therapist/Gym** |

|  |  |
| --- | --- |
| Is this person being supported by any other organisation in the community **If yes please state which one/s** |  |
| Are there any health or behavioural factors that we should be aware of prior to a home visit? |  |

**Additional information**

|  |  |
| --- | --- |
| Do they live alone? | **YES  NO**  If no, who with (Please State) |
| What is the access to the property like? | **Are there stairs/lifts and or poor lighting etc**. |
| Do they have any Pets? | **YES  NO**  If yes, (Please State) |

**Thank you for your referral**

**If you would like to discuss this referral please call 020 8525 3206**

**Please provide any further information you think we need to have in order to support**