****

**Please state below the contact details of the client you wish to refer to the Timebank:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** |  | **SURNAME** |  |
| **ADDRESS**  |  | **TEL:****MOBILE:** |  |
|  |
| **POST CODE** |  | **DATE OF BIRTH** |  |
| **EMAIL** |  |

**Please state below your clients attributes:**

|  |
| --- |
| **ATTRIBUTES** |
| **Habits** |  |
| ***Please tick all that apply*** | **Tick** |
| **Smoker** |  |
| **Smoke tolerant** |  |
| **Smoke intolerant** |  |
| **Pet owner** |  |
| **Dog tolerant** |  |
| **Dog intolerant** |  |
| **Cat allergies** |  |
| **Living Group** |  |
| **Lives with family** |  |
| **Lives with others** |  |
| **Lives with partner or spouse** |  |
| **Lives alone** |  |
| **Housing** |  |
| **House** |  |
| **Hostel** |  |
| **Flat** |  |
| **Bungalow** |  |
| **Lift** |  |
| **No lift** |  |
| **Sheltered accommodation** |  |
| **Residential accommodation** |  |
| **Mobility** |  |
| **Needs wheelchair** |  |
| **Needs walker / walking stick / crutches** |  |
| **Cannot manage stairs** |  |

|  |  |
| --- | --- |
| **Health issues** |  |
|  | **Please state to what degree:** |
| **Visual Impairment** |  |
| **Deafness** |  |
| **Dementia** |  |
| **Any other medical conditions that our timebank members should be aware of?** |  |

|  |  |
| --- | --- |
| **Care packages** |  |
| **If possible, please state what care packages are currently in place (include days & times).**  |

 **Please describe the nature of the request for support:**

**Please list the hobbies & interests of the client you wish to refer to the timebank. Anything they *enjoy* doing. This will help us with the match-making process, ensuring we assign a timebank befriender with similar interests:**

***Please email completed forms to: philip@warringtonva.org.uk***