Please return completed form to WRHA Volunteer Services at [volunteer@wrha.mb.ca](mailto:volunteer@wrha.mb.ca)

**Request Form**

**FRIENDLY PHONE CALL SERVICE (for clients in a WRHA Community Health Program)**

**1. Service Provider Referring *(Please Print)***

|  |  |
| --- | --- |
| Name: |  |
| Position: |  |
| Program Area & Community Area: |  |
| Address: |  |
| Work Phone: |  |
| Email Address: |  |
| Name of Staff who will be the Volunteer’s Placement Supervisor: |  |

**2. Client Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Client’s Full Name: |  | | Preferred to be Referred to as: | |  | |
| Client’s Preferred Title: | **Mr.** | **Mrs.** | **Ms.** | **Miss.** | **Dr.** | Other *(specify)* |
| Client’s Phone Number: |  | | Client’s Age: | |  | |
| Languages Spoken: |  | | | | | |
| Which WRHA Community Health program is the client receiving services from:  Home Care  Mental Health  Primary Care  Public Health  Other (*specify*) | | | | | | |
| Has the client consented to having a volunteer call them? (Ensure this is documented in Client’s chart)  **Yes  No** | | | | | | |
| Reason for referral to use the Friendly Phone Call Service (e.g. lack of social contacts, inability to access community programming, feelings of loneliness): | | | | | | |
| **Client must be medically and/or emotionally stable for this service. Please answer the following questions:**  Is the client capable of establishing and maintaining a relationship with others?  **Yes  No**  Is the client a risk for suicide?  **Yes  No**  Does the client have any medical conditions that would put the volunteer at risk of developing an over the phone relationship with?  **Yes  No** | | | | | | |
| Please ask your client:  **When looking at a weekly basis, how often do you feel lonely? Please c*heck one.***   |  |  |  |  | | --- | --- | --- | --- | | All of the time  *(e.g. 5-7 days)* | Occasionally or a  moderate of time  *(e.g. 3-4 days)* | Some or a little of  the time *(e.g. 1-2*  *days)* | Rarely or none  of the time *(e.g.*  *less than 1 day)* | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the client  prefer a: | **Female Volunteer** | **Male Volunteer** | **Doesn’t Matter** |
| The volunteer will call once a week at a time that is mutually agreed upon between the client and volunteer. We prefer the calls to be made Monday to Friday. Does the client have a preference:  **Weekdays, days  Weekdays, evenings  Anytime** | | | |

**3. Background**

|  |
| --- |
| What background information (e.g. activities, interests, hobbies, occupation, personality, habits, etc.) does the client want the volunteer to know about them? |

|  |
| --- |
| **Please note: It is the responsibility of the staff in the program / service area making the volunteer request to provide the necessary supports for volunteers to do their work, including monthly contact with the volunteer and client to ensure the relationship (calls) are occurring as arranged and informing the volunteer of any changes with the client. If the client is no longer receiving service from your program (i.e. discharged, deceased, etc.), then please notify the volunteer and WRHA Volunteer Services.** |

     

Signature of Volunteer Placement Supervisor (Requestor) Date

*The below is to be filled out by WRHA Volunteer Services and will be returned to the requestor when a match is made.*

**WRHA Volunteer Services – Friendly Phone Service**

**Volunteer Match**

Client’s Full Name:

Volunteer’s Name:

Volunteer’s Phone Number:

Volunteer’s Email Address:

     

Signature of Volunteer Services Staff Date

**Once a match has been made, it is the responsibility of the placement supervisor (Healthcare Provider) to connect the volunteer with the client.**