Community Advocacy

Referral Form for Community, Generic & Non-statutory Advocacy

If you are making a referral for advocacy support on behalf of another person, the referral can only be accepted if the person needing an advocate has given their consent.

0 Office Use Only

Case reference

Date referral received

Advocacy service referred to

Advocate/Team

1 Consent

Do you have the consent of the person requiring advocacy? (if unable, please give a reason)

Yes No Unable to consent

2 Referrer Details

Date of referral

Organisation (if referring on a professional basis)

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

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2 Referrer Details cont.

Job Title/Relationship to Client

Doctor	Psychiatrist	Ward Manager
Care Manager	Care Home Manager	Team Manager (Health)
Team Manager (Social)	Social Worker (Hospital)	Social Worker (Community)
Nurse (Health Professional)	Administrator	Carer
Parent	Child	Partner
Spouse	Neighbour	Friend
Other (please specify)		

3 Client Details

Title

Date of Birth

First Name

Last Name

Permanent Address

Postcode

Telephone Number

Email Address

Mobile Number

Current Address **(if different from above)**

Postcode

Telephone Number

Preferred method of contact

Any	Phone	Mobile
SMS (Text)	Email	Post
No Direct Contact		

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3 Client Details cont.

Location Setting

Own home
Own home (with support)
Supported Living
Hospital
Care/Nursing Home
Dementia Ward
Acute Psychiatric Ward
Forensic Secure Unit
Prison
Homeless
No fixed abode
Other/Ward Name (if in hospital)

Is English Spoken?

Yes
No
Not known

Primary Communication Method

Spoken English
Words/Pictures/Makaton
British Sign Language (BSL)
Not known
Other spoken language (specify below)
Gestures/Expressions/Vocalisations
No Obvious Means
Other (please specify other spoken languages here)

Does the client identify as having a disability?

Yes
No
Not known
Prefers not to say

Does the client have a diagnosed or recognised disability? (select all that apply)

Mental Health Condition
Acquired Brain Injury
Serious Physical Illness
Physical Disability
Learning Disability
Cognitive Impairment
Sensory (Visual)
Sensory (Auditory)
Dementia/Alzheimer's
Asperger's/Autistic Spectrum Condition
Unconsciousness
Other (please specify)

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3 Client Details cont.

Is there one disability which is most relevant to the case? (If there is not, leave blank)

Mental Health Condition
Acquired Brain Injury
Serious Physical Illness
Physical Disability
Learning Disability
Cognitive Impairment
Sensory (Visual)
Sensory (Auditory)
Dementia/Alzheimer's
Asperger's/Autistic Spectrum Condition
Unconsciousness

Military Connection

Serving
Veteran
Carer relationship
No
Not known
Prefers not to say

Gender

Male
Female
Trans (Male to Female)
Trans (Female to Male)
Not known
Prefers not to say
Other (please specify)

Sexual Orientation

Lesbian
Gay Man
Heterosexual
Bisexual
Questioning
Not known
Prefers not to say
Other (please specify)

Marital/Civil Partnership Status

Single
Co-habiting
Married
Civil Partnership
Divorced/Dissolved
Separated
Widowed
Surviving (Civil Partnership)
Not known
Prefers not to say

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3 Client Details cont.

Belief

Buddhist	Christian	Hindu
Jewish	Muslim	Sikh
No Religion	Not known	Prefers not to say
Other (please specify)		

Ethnicity

Asian/Asian British

Indian
Pakistani
Chinese
Bangladeshi
Other (please specify)

Black/Black British

African
Caribbean
Other (please specify)

White

British
Irish
Gypsy/Traveller
Other (please specify)

Mixed

White & Black Caribbean
White & Black African
White & Asian
Other (please specify)

Other

Arab
Other (please specify)

Not known
Prefers not to say

Does the client identify as Cornish?

Yes   No   Not known

4 Case Details

Local Authority (Council of client's location)

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4 Case Details cont.

Information about the need for advocacy support

What is the main issue?

Are there any dates/times the client can't be contacted?

When would the client prefer to be contacted?

Morning Afternoon Either

Enter dates, times and venues of any important meetings or other deadlines

If there are any risks we should be aware of give details (otherwise state 'no known risks')

Additional information

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4 Case Details cont.

Emergency contact information

Name

Relationship to client

Phone

5 Declaration

In making this referral, I declare that:

- I wish to request advocacy support from The Advocacy People.
- I understand that client information will be stored safely on a computer.
- I confirm that I am either a self-referring client or I have consent from the client to make the referral, or I have the authority to make the referral for the client.
- I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
- I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

Please email the completed form to: **info@theadvocacypeople.org.uk**
or post to: **P.O. Box 375, Hastings, TN34 9HU**

If you have not received confirmation of this referral within **3 working days**, or you would like to discuss any aspects of a referral, please call **0330 440 9000**.

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service.
For more information on our Privacy Policy, please ask your advocate or go to www.theadvocacypeople.org.uk/privacy

Confidentiality
Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.

The Advocacy People