**Community / Generic / Non-statutory Advocacy Referral**

Referrals can only be accepted if the person needing an advocate has given their consent. If you believe they do not have the capacity to consent, please give brief details in the ‘Additional Information’ section of this form on page 4.

**If you need help with this form, call us on 0330 440 9000 or Text PEOPLE to 80800**

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** | | | | |
| **Referrer’s Details** | | | | |
| **Referrer First Name:** | | | **Last Name:** | |
| **Are you referring on a Professional basis?**  Yes  No | | | | |
| **Organisation** (write ‘none’ if not applicable) | | | | |
| **Job Title** (if applicable) | | | | |
| **Relationship to Client** (check **ONE** box only) | | | | |
| Doctor | Psychiatrist | | | Ward Manager |
| Care Manager | Care Home Manager | | | Team Manager Health |
| Nurse / Health Professional | Social Worker (Hospital) | | | Social Worker (Community) |
| Team Manager Social Care | Administrator | | | Carer |
| Parent | Child | | | Spouse |
| Partner | Other Relative | | | Neighbour |
| Friend | Other (specify) | | | |
| **Address:** | | | | |
| **Postcode:** | | | | |
| **Tel No:** | | **Mobile No:** | | |
| **Email:** | | | | |

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| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? | | | | | | | |
| Check **ONE** box only | | | | | | | |
| Mental Health Condition  Physical Disability  Sensory (Hearing)  Sensory (Sight) | | Asperger’s /Autism Spectrum Condition  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | | | | | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |
| If any condition not listed is significant to the case, please call us on 0330 440 9000 | | | | | | | |
| **Client Information** | | | | | | | |
| **Title:**  Mr  Mrs  Ms  Other | | | **First Name:**  **Last Name:** | | | | |
| **Date of Birth:** | | | | | | | |
| **Permanent Address:** |  | | | | | | |
| **Postcode:** | | | | | | | |
| **Telephone No.** | | | | | **Mobile No.** | | |
| **E-mail** | | | | | | | |
| **Preferred method of contact:** | | | | | | | |
| Any  Telephone  E-mail  Post  Mobile Phone  Text  Cannot be contacted directly | | | | | | | |
| **Does the client consider themselves to have a disability?**  **Does the Client consider themself to have a disability?** | | | | | | | |
| Yes  No  Not known  Prefers not to say | | | | | | | |
| **What types of disability or impairment does the Client have?** Select **ALL** that apply | | | | | | | |
| Mental Health Condition  Acquired Brain Injury  Physical Disability  Serious Physical Illness  Sensory (Hearing)  Learning Disability  Sensory (Sight)  Dementia / Alzheimer’s  Asperger's/Autism Spectrum Condition  Unconsciousness  Cognitive Impairment  Other (specify) | | | | | | | |
| **What is the Client’s primary communication method?**  Spoken English  Other Spoken Language (specify)  British Sign Language (BSL)  Other (specify)  Words/Pictures/Makaton  No obvious means of communication  Gestures/Facial Expressions/Vocalisations Not known | | | | | | | |
| **Is English Spoken?**  Yes  No | | | | | | | |
| **Gender**  Male  Female  Transgender F to M  Transgender M to F Prefers not to say  Other (specify) | | | | | | | |
| **Does the Client identify themself as Cornish?** Yes  No  Not known | | | | | | | |
| **Sexual Orientation** | | | | | | | |
| Lesbian  Gay Man  Heterosexual  Bisexual  Questioning  Not known  Prefers not to say  Other (specify) | | | | | | | |
| **Ethnic Background** | | | | | | | |
| **White**  British  Irish  Gypsy or Irish Traveller  Any other White background (specify)    **Mixed Ethnic Groups**  White & Black Caribbean  White & Black African  White & Asian  Any other Mixed ethnic background (specify)    **Black / Black British**  African  Caribbean  Any other Black/African/Caribbean background (specify) | | | | | | **Asian / Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (specify)  **Other Ethnic Group**  Arab  Any other ethnic group (specify)    Ethnicity not known  Prefers not to say | |
| **Marital or Civil Partnership Status** | | | |  | | | |
| Single  Separated (but still legally married / in civil partnership)  Co-habiting  Divorced or Civil Partnership Dissolved  Married  Widowed  In Civil Partnership  Surviving partner of Civil Partnership  Not known  Prefers not to say | | | | | | | |
| **Religion or Belief** | | | |  | | | |
| Buddhist  Christian (all denominations)  Hindu  Jewish  Muslim  Sikh  No Religion  Not known  Prefers not to say  Other (specify) | | | | | | | |
| **Military Connection**  **oes the Client have a Military connection?** | | | | | | | |
| Yes, Serving  Yes, Veteran  Yes, Carer relationship  No  Not known  Prefers not to say | | | | | | | |

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| **Client Location Details** |
| **Client’s current location:**  Own Home  Dementia Ward  Hospital  Own Home with Support  Care / Nursing home  Homeless  Supported Living  Prison  No Fixed Abode  Acute Psychiatric Unit  Forensic Secure Unit  Other Institution |

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| **Is Client currently at their permanent address?**  Yes  No (If No, give details below) | |
| **Current Address:** |  |
| **Postcode:** | |
| **Telephone No.** | |
| **Ward Name (if in Hospital):** | |

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| **Advocacy Referral Details** |
| **Local Authority (Council) of Client Location:** |
| **Does the person requiring an advocate give their consent to the referral?**  Yes  Unable to Consent (give brief details under ‘Additional information’) |

**Main Referral Issue** (e.g. benefits, housing, finance, complaint, health, social care, access to services, family, caring role etc.)

(Please note, not all issues are supported in all areas. To check, please call 0330 440 9000)

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| **Additional Information (about the client)** |
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**Best time to contact the client?**

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| --- | --- | --- |
| Morning | Afternoon | Morning or Afternoon |

**Are there any dates when the client can’t be contacted?**

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**Does the client have any special needs we should consider when contacting or visiting?**

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**Are there any risks we should be aware of when visiting or arranging to meet the client?**

If you are not aware of any risks, please write 'no known risks'

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**Are there any deadlines or important meeting dates?**

If this is within 3 working days of now, an advocate will probably **not** be there

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**What help is needed from an Advocate?**

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| **May we contact the client directly?**  Yes  No |

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| **Emergency Contact Name:** |
| **Emergency Telephone Number:** |
| **Emergency Contact Relationship:** |

Data Protection law says we need to make sure you agree that we can keep personal information about you.

**Declaration:**

* 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 e-mail the completed form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk)

or post to P.O. Box 375, Hastings TN34 9HU

If you have not heard from us within 3 working days, please contact The Advocacy People on **0330 440 9000** or Text **PEOPLE** to **80800** (followed by your message)

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](http://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.