**Children & Young Person’s Advocacy Referral**

In order to make a referral to our services we need the consent of the child or young person being referred and/or their parent, as appropriate.

Do you have the consent of the child/young person?

Yes  No  Unable to consent (please give details)

Do you have the consent of his/her parent?

Yes  No  N/A

**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.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Referral:** Click or tap to enter a date. | | | | |
| **Referrer’s Details** | | | | |
| **Referrer First Name:** | | | **Last Name:** | |
| **Organisation** (N/A if not a professional referral) | | | | |
| **Job Title** (N/A if not a professional referral) | | | | |
| **Relationship to Client** | | | | |
| Health Professional | Social Worker | | | Family Member/Friend |
| Carer | Other professional (specify) | | | |
| **Address:** | | | | |
| **Postcode:** | | | | |
| **Tel No.:** | | **Mobile No.:** | | |
| **Email:** | | | | |
| **Social Worker’s Details** (if different from referrer) | | | | |
| **Name:** | | | | |
| **Tel No.:** | | | | |
| **Email:** | | | | |

|  |
| --- |
| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? |
|  |
| If any condition not listed is significant to the referral, please add here |

|  |  |  |  |
| --- | --- | --- | --- |
| **Child/Young Person’s Information** | | | |
| **First Name(s):**  **Last Name:** | | | |
| **Date of Birth:** | | | **Legal Status:** |
| **Permanent Address:** |  | | |
| **Postcode:** | | | |
| **Child/Young Person’s current location:** Other: | | | |
| **Current Address:** (if different from permanent address) |  | | |
| **Postcode:** | | | |
| **Can the child/young person be contacted directly?** Yes No | | | |
| **If yes,** preferred method of contact & contact details | | | |
| **Telephone No.** | | **Mobile No.** | |
| **Email** | | | |
| **If no,** please provide name & contact details of who we should approach | | | |
| **Name:**  **Telephone No.** | | **Relationship to child/young person:**  **Mobile No.** | |
| **Email** | | | |
| **School contact name & number:** | | | |
| **Other agencies involved:** | | | |
| **Does the child/young person consider themselves to have a disability?** | | | |
| **What types of disability or impairment does the child/young person have?** Select **ALL** that apply | | | |
| Mental Health Problem  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) | | | |
| **Does the child/young person have an EHCP?** Yes  No | | | |
| **What is the child/young person’s primary communication method?**  Other: | | | |
| **Is English Spoken?**  Yes  No | | | |
| **Gender:** Other: | | | |
| **Sexual Orientation:** Other: | | | |
| **Ethnic Background:** Other: | | | |
| **Religion or Belief:** Other: | | | |

|  |
| --- |
| **Advocacy Referral Details** |
| **Advocacy support needed** |
| **Please outline reason for referral (what help is needed from an advocate)** |
| **Date, time & venue of any meetings to be attended** |
| **Please detail any risks or behaviours the Advocate needs to be aware of when dealing with the referral.** If you are not aware of any risks, please write 'no known risks' |
| **Additional information that may be relevant such as special needs** |

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 have consent from the client/their parent(s) 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 form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk) **or post to** PO Box 375, Hastings, TN34 9HU

If you have not heard from us within 24 hours (excluding weekends and Bank Holidays), please contact The Advocacy People on **0330 440 9000** or email[**info@theadvocacypeople.org.uk**](mailto:info@theadvocacypeople.org.uk)

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.