# Community Advocacy

Referral Form for Community, Generic & Non-statutory Advocacy

the advocacy people

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 | ☐ | Other spoken language (specify below) | ☐ |
| Words/Pictures/Makaton | ☐ | Gestures/Expressions/Vocalisations | ☐ |
| British Sign Language (BSL) | ☐ | No Obvious Means | ☐ |
| Not known | ☐ | | |

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 Notice, 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