

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	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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**the
advocacy
people**

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