

Children & Young Person's Advocacy

Referral Form for Children & Young Person's Advocacy



0 Office Use Only

Case reference	Date referral received
Advocacy service referred to	Advocate/Team

1 Consent

Do you have the consent of the child/young person? (if unable, please give a reason)

Yes No Unable to consent

Do you have the consent of the parent/guardian?

Yes No Not Applicable

2 Referrer Details

Date of referral	Organisation (if applicable)	
First Name	Last Name	
Address	Postcode	
	Telephone Number	
Email Address	Mobile Number	
Job Title/Relationship to Client		
Health Professional	Social Worker	Family/Friend
Carer		
Other (please specify)		

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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

Location Setting		
With family	Foster care	Children's home
Shared Lives	Supported Living	Hospital
Care/Nursing home	Acute Psychiatric Ward	Forensic Secure Unit
Prison/YOI	Homeless	No fixed abode
Other (please specify)		

Child/young person's preferred method of contact		
Any	Phone	Mobile
SMS (Text)	Email	Post
No Direct Contact		

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3 Client Details cont.

If we can't contact the child/young person directly, who should we contact?

Name Relationship to client

Phone Email

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)		

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

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3 Client Details cont.

Military Connection

Serving
No

Veteran
Not known

Carer relationship
Prefers not to say

Gender

Male
Trans (Female to Male)
Other (please specify)

Female
Not known

Trans (Male to Female)
Prefers not to say

Sexual Orientation

Lesbian
Bisexual
Prefers not to say
Other (please specify)

Gay Man
Questioning

Heterosexual
Not known

Marital/Civil Partnership Status

Single
Civil Partnership
Widowed
Prefers not to say

Co-habiting
Divorced/Dissolved
Surviving (Civil Partnership)

Married
Separated
Not known

Belief

Buddhist
Jewish
No Religion
Other (please specify)

Christian
Muslim
Not known

Hindu
Sikh
Prefers not to say

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3 Client Details cont.

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)

Child Legal Status

What help is needed from the advocate?

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4 Case Details cont.

What is the main issue?

Child in care

Child Protection Plan

Not Known

Care leaver

Making a complaint

Young carer

SEND (Special Educational Needs & Disabilities)

Other (please specify)

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 that may be relevant (such as special needs)

Social Worker Contact Details (if different to the person making this referral)

Name

Phone

Email

School Contact Details

Name

Phone

Email

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4 Case Details cont.

Other agencies involved

Does the client have an EHCP? (Education & Health Care Plan)

Yes No

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 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 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