

## Independent Visitor 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/guardian, 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 the parent/guardian?

Yes  No  N/A

**If you need help with this form, call us on 0330 440 9000**

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

<b>Date of Referral:</b>	
<b>Referrer's Details</b>	
<b>Referrer First Name:</b>	<b>Last Name:</b>
<b>Are you referring on a Professional basis?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Organisation</b> (write 'none' if not applicable)	
<b>Job Title</b> (if applicable)	
<b>Relationship to Client</b> (check <b>ONE</b> box only)	
<input type="checkbox"/> Health Professional	<input type="checkbox"/> Social Worker <input type="checkbox"/> Family/Friend
<input type="checkbox"/> Carer	<input type="checkbox"/> Other (specify)
<b>Address:</b>	
<b>Postcode:</b>	<b>Mobile No:</b>
<b>Tel No:</b>	
<b>Email:</b>	

<b>Client Information</b>	
<b>Title:</b> <input type="checkbox"/> Mr <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other	<b>First Name:</b>  <b>Last Name:</b>
<b>Date of Birth:</b>	
<b>E-mail</b>	
<b>Telephone No.</b>	<b>Mobile No.</b>

<b>Permanent Address:</b>			
<b>Postcode:</b>			
<b>Current Address</b> (if different from above):			
<b>Postcode:</b>			
<b>Location Setting</b>			
<input type="checkbox"/> With family	<input type="checkbox"/> Foster care	<input type="checkbox"/> Children's home	
<input type="checkbox"/> Shared Lives	<input type="checkbox"/> Supported Living	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Care/Nursing home	<input type="checkbox"/> Acute Psychiatric Unit	<input type="checkbox"/> Forensic Secure Unit	
<input type="checkbox"/> Prison/YOI	<input type="checkbox"/> Homeless	<input type="checkbox"/> No fixed Abode	
<input type="checkbox"/> Other (specify)			
<b>Child/young person's preferred method of contact:</b>			
<input type="checkbox"/> Any	<input type="checkbox"/> Telephone	<input type="checkbox"/> E-mail	<input type="checkbox"/> Post
<input type="checkbox"/> Mobile Phone	<input type="checkbox"/> Text	<input type="checkbox"/> Cannot be contacted directly	
<b>If we can't contact the child/young person directly, who should we contact?</b>			
<b>Name:</b>		<b>Relationship to client:</b>	
<b>Phone:</b>		<b>Email:</b>	
<b>Social Worker Contact Details</b> (if different to the person making this referral)			
<b>Name:</b>		<b>Relationship to client:</b>	
<b>Phone:</b>		<b>Email:</b>	
<b>School Contact Details</b>			
<b>Name:</b>		<b>Relationship to client:</b>	
<b>Phone:</b>		<b>Email:</b>	
<b>What is the Client's primary communication method?</b>			
<input type="checkbox"/> Spoken English	<input type="checkbox"/> Other Spoken Language (specify)		
<input type="checkbox"/> British Sign Language (BSL)	<input type="checkbox"/> Other (specify)		
<input type="checkbox"/> Words/Pictures/Makaton	<input type="checkbox"/> No obvious means of communication		
<input type="checkbox"/> Gestures/Facial Expressions/Vocalisations	<input type="checkbox"/> Not known		
<b>Is English Spoken?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Does the client consider themselves to have a disability?</b>			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Not known	<input type="checkbox"/> Prefers not to say		

**What types of disability or impairment does the Client have? Select ALL that apply**

- |   |   |
|---|---|
| <input type="checkbox"/> Mental Health Condition              | <input type="checkbox"/> Acquired Brain Injury    |
| <input type="checkbox"/> Physical Disability                  | <input type="checkbox"/> Serious Physical Illness |
| <input type="checkbox"/> Sensory (Hearing)                    | <input type="checkbox"/> Learning Disability      |
| <input type="checkbox"/> Sensory (Sight)                      | <input type="checkbox"/> Dementia / Alzheimer's   |
| <input type="checkbox"/> Asperger's/Autism Spectrum Condition | <input type="checkbox"/> Unconsciousness          |
| <input type="checkbox"/> Cognitive Impairment                 | <input type="checkbox"/> Other (specify)          |

**Gender**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Male               | <input type="checkbox"/> Female          | <input type="checkbox"/> Transgender F to M | <input type="checkbox"/> Transgender M to F |
| <input type="checkbox"/> Prefers not to say | <input type="checkbox"/> Other (specify) |   |   |

**Religion or Belief**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Buddhist        | <input type="checkbox"/> Christian (all denominations) | <input type="checkbox"/> Hindu              |
| <input type="checkbox"/> Jewish          | <input type="checkbox"/> Muslim                        | <input type="checkbox"/> Sikh               |
| <input type="checkbox"/> No Religion     | <input type="checkbox"/> Not known                     | <input type="checkbox"/> Prefers not to say |
| <input type="checkbox"/> 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

## Key Characteristics of the Young Person

<b>Please describe the young person's interests and hobbies</b>	
<b>Young person's Health details:</b>  Including allergies or phobias	
<b>Young person's Emotional &amp; Behavioural development:</b>	
<b>Young person's Family &amp; Social relationships:</b>	
<b>Young person's Identity &amp; Social Presentation:</b>	
<b>Young person's Employment/Training/ Further Education Plans:</b>	
<b>Summary:</b>	

## Appointing an Independent Visitor

Is the young person in agreement with appointing an Independent Visitor?

Yes  No

Has the decision to seek the appointment of an Independent Visitor been agreed at a Statutory Review?

Yes  No

What are the qualities sought in an Independent Visitor? Male or Female?

In addition should the IV be a parent or grandparent-type figure or an older sibling or friend-type?

This is ideal world and dependent on volunteers available.

## Risk Assessment

Type of risk (please tick as applicable)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Violence to others                 | <input type="checkbox"/> Sexual assault against children | <input type="checkbox"/> Self neglect  |
| <input type="checkbox"/> Verbal abuse                       | <input type="checkbox"/> Vulnerable to abuse by others   | <input type="checkbox"/> Illicit drug misuse                                     |
| <input type="checkbox"/> Self-injurious behaviour           | <input type="checkbox"/> Fire setting                    | <input type="checkbox"/> Alcohol abuse   |
| <input type="checkbox"/> Attempted suicide                  | <input type="checkbox"/> Damage to property              | <input type="checkbox"/> Theft   |
| <input type="checkbox"/> Inappropriate sexualised behaviour | <input type="checkbox"/> Anti-social behaviour           | <input type="checkbox"/> Risk to professionals or volunteers from family/friends |
| <input type="checkbox"/> Other (specify)                    |  |  |

## Risk Strategies

Behaviour(s):

Antecedents: i.e. what triggers the behaviour(s)

<b>Frequency and severity</b>
<b>Consequences</b> (what have been the consequences of previous episodes of this behaviour)
<b>Action Plan - what should the Independent Visitor do:</b> <b>(a) to minimise the risk of the behaviour occurring</b> <b>(b) in response to the behaviour</b>
<b>Special Precautions that need to be observed e.g. foods to be avoided/locations to be avoided etc.</b> For example - Are there risks associated with the volunteer being in the community with the young person?
<b>Does the young person agree to this assessment and strategy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

Please now complete activity consent on the following page

## Activity Consent

In the normal course of their meetings young people and their Independent Visitors might do various normal everyday activities such as:

- Café/Restaurant
- Cinema/Theatre/Circus
- Bowling
- Walks in the park/Country parks
- Cycling
- Museums/Galleries/Library
- Zoos/Farms/Aquariums/Safari parks
- Makeovers
- Dog walking
- Trips to castles/stately homes/guided tours
- Shopping
- Football/other sports
- Watching sport
- Indoor/outdoor Children's Adventure Playgrounds
- Visitor Centre/Community Centre
- Cookery sessions
- Arts and Crafts

**Do you give consent for the young person to partake in these activities?**  Yes  No

**Please state which you do not consent to and reasons why:**

More hazardous activities young people and their Independent Visitors might do:

- Ice skating/Roller blading
- Horse riding
- Public swimming pools/Waterparks
- Go-karting
- Trampolining
- Lazerquest
- Chill Factor
- Go Ape
- Rock climbing/Abseiling/Clip 'n' Climb
- Cycling on roads
- Segway
- Theme parks

**Do you consent for the young person to participate in these more hazardous activities?**

Yes  No

**Please state which you do not consent to and reasons why:**

**Do you consent to the young person receiving medical treatment in an emergency from a trained response worker?**

Yes  No

**Do you consent to the young person travelling in a volunteer's car?**  Yes  No

**Do any additional measures need to be taken?**

**Form completed by**

**Date completed**

Once the referral is received we will confirm receipt and contact you to discuss next step.

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.