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| For office use only | I.D. |  |

**Generic/General Advocacy Referral**

**(Community, Financial, Practical Support)**

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| Date of referral |  |

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| **Client information** | | | | | | | | | | | |
| Verbal consent received | YES |  | NO |  | Data Protection Statement read and understood | | | YES |  | NO |  |
| Title (Mr, Mrs, Ms) | | |  | | | | Gender |  | | | |
| First Name | | |  | | | | | | | | |
| Surname | | |  | | | | | | | | |
| Date of birth | | |  | | | | | | | | |
| Home address | | |  | | | | | | | | |
| Post Code | | |  | | | | | | | | |
| Telephone number | | |  | | | | | | | | |
| Mobile number | | |  | | | | | | | | |
| Email | | |  | | | | | | | | |
| NOK / Emergency contact name | | | | | |  | | | | | | |
| NOK / Emergency contact relationship | | | | | |  | | | | | | |
| NOK / Emergency telephone number | | | | | |  | | | | | | |

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| **Preferred method of contact** | | | |
| Telephone |  | Mobile |  |
| Text |  | Email |  |
| Post |  | Any |  |

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| **Client’s primary communication method** | | | |
| Spoken English |  | British Sign Language (BSL) |  |
| Other spoken language (please specify and also whether English is spoken) |  | Gestures/Facial expressions/Vocalisations |  |
| Words/Pictures/Makaton |  | Other (please specify) |  |

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| **Does the client have any disability or impairment? (select all that apply)** | | | |
| Mental health problem |  | Physical disability |  |
| Acquired brain injury |  | Serious physical illness |  |
| Sensory (hearing) |  | Sensory (sight) |  |
| Learning disability |  | Dementia/Alzheimer’s |  |
| Asperger’s/Autism Spectrum Condition |  | Cognitive impairment |  |
| Other (please specify ) |  |  |  |

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| **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”** |
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| **Type of Advocacy / Support needed** | | | |
| Income Benefits |  | Housing/ Accommodation |  |
| Debt / Managing Finances |  | Safeguarding |  |
| Accessing Services |  | General Advocacy |  |

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| **Describe the current circumstances and what support is needed from the Advocacy service.** |
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| **Referrer’s details** | | | |
| First name |  | Surname |  |
| Organisation |  | Job Title |  |
| Telephone |  | Mobile |  |
| Email |  | | |

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| **Signature of referrer** |
|  |

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| **Referral Background Information** | |
| **Name of Referee** |  |
| **Company of Referee** |  |
| **How did you hear about the Hub?** |  |

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| --- | --- |
| **Monitoring Information** | |
| **Ethnicity** |  |
| **Sexual Orientation** |  |
| **Religion** |  |

Please email the completed form to: [advocacy@southessexadvocacy.org](mailto:advocacy@southessexadvocacy.org)

Or post to: Southend Advocacy Hub

Unit 2, 225-235 West Road

Westcliff-on-Sea

Essex SS0 9DE