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

**General Advocacy Referral**

**(Community, Financial, Child Protection)**

**Please complete as many of the boxes as possible to ensure there are no delays to the referral**

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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 |  |
| National Insurance Number |  |
| NHS Number |  |
| Local Authority Number |  |
| 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) |  | None |  |

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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** |
| Financial (Benefits, Debts) |  | Accommodation |  |
| Accessing Services (Health, Mental Health, Social Services, Care/Support) |  | Safeguarding |  |
| Child Protection(only available to parents experiencing substantial difficulty i.e. Learning Disability / Mental Health Diagnosis AND who are without family/friends support) |  | Other |  |

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| **Describe in detail 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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| **Monitoring Information** |
| **Ethnicity** |  |
| **Sexual Orientation** |  |
| **Religion** |  |

Please email the completed form to: advocacy@southessexadvocacy.org

Or post to: Southend Advocacy Hub

 Unit 2, 225-235 West Road

 Westcliff-on-Sea

 Essex SS0 9DE