

CONFIDENTIAL

First Name:		Surname:	
Date of Birth:			
Home Address & Postcode:			
Current location if different from above (including telephone and ward details)			
Telephone Number:			
Mobile Number:			
Email Address:			
Funding Authority:			
Preferred method of contact:	Phone	Email	Post

Is the person aged 16-17yrs old and at risk of homelessness?	Yes	No
Does this person have any communication needs?		
Please detail any known risks		

CONSENT - Advocacy Operates under the GDPR Guidelines

If the person being referred is deemed to lack capacity, please sign below to say that you are referring in the client's best interest

Is this child or young person aware of the referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of referrer:		

Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Prefer not to say
	<input type="checkbox"/> Female, male at birth	<input type="checkbox"/> Male, female at birth	<input type="checkbox"/> Other, please specify
	<input type="checkbox"/> Non-binary		

Pronouns:	<input type="checkbox"/> He/him	<input type="checkbox"/> She/her	<input type="checkbox"/> They/them	_____
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Sexual Orientation:	<input type="checkbox"/> Asexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Heterosexual
	<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Prefer not to say	<input type="checkbox"/> Other, please specify _____

Disability:	<input type="checkbox"/> Acquired brain injury	<input type="checkbox"/> Multiple impairments	<input type="checkbox"/> Neurological conditions
	<input type="checkbox"/> Carer	<input type="checkbox"/> Older person	<input type="checkbox"/> Physical disability
	<input type="checkbox"/> Dementia	<input type="checkbox"/> Sensory impairment	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Long term health condition	<input type="checkbox"/> Substance misuse	<input type="checkbox"/> Other (please specify)
	<input type="checkbox"/> Autism	<input type="checkbox"/> Learning disability	_____
	<input type="checkbox"/> Communication difficulties	<input type="checkbox"/> Mental health	_____

Ethnic Origin:	<input type="checkbox"/> African	<input type="checkbox"/> Arab/British Arab	<input type="checkbox"/> Asian/British Asian
	<input type="checkbox"/> Black/Black British	<input type="checkbox"/> Carribean	<input type="checkbox"/> Chinese
	<input type="checkbox"/> European	<input type="checkbox"/> Gypsy/Roma	<input type="checkbox"/> Indian
	<input type="checkbox"/> Mixed heritage	<input type="checkbox"/> Pakistani	<input type="checkbox"/> White British
	<input type="checkbox"/> White Irish	<input type="checkbox"/> White other	<input type="checkbox"/> Prefer not to say
	<input type="checkbox"/> Other, please specify: _____		

Religion:	<input type="checkbox"/> Atheist <input type="checkbox"/> Catholic <input type="checkbox"/> Christian <input type="checkbox"/> Jewish	<input type="checkbox"/> Sikh <input type="checkbox"/> Buddhist <input type="checkbox"/> Hindu <input type="checkbox"/> Muslim	<input type="checkbox"/> Jehovah Witness <input type="checkbox"/> Not known <input type="checkbox"/> No religion <input type="checkbox"/> Other, please specify: _____
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Please provide Referrer and Decision-Maker details

	Referrer	Decision Maker
Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

Safe parent/Carer/Guardian details

Name:	
Relationship to Child or Young Carer:	
Telephone Number:	
Mobile Number:	
Is this child or young person aware of the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Upcoming meetings

Are there any upcoming meetings that we need to be aware of? Please can you detail below providing dates, time and location (in person or virtual):

Area of Advocacy required

Children & Young Person's Advocacy Under Children Act :	<input type="checkbox"/> Child in Need Plan / Section 17 <input type="checkbox"/> Child Protection / Section 47 Enquiry (ICPC) <input type="checkbox"/> Looked after Child/ Section 20 <input type="checkbox"/> Child Protection Plan / Section 47 <input type="checkbox"/> Interim Care Order <input type="checkbox"/> Full Care Order	<input type="checkbox"/> Care Leaver (Post 18) <input type="checkbox"/> Social Care Complaint
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Young Person Preparing for Adulthood - Advocacy Only Under Care Act

Children's Care Act Advocacy - please complete all below sections for us to be able to triage the referral

Children's Care Act Advocacy		Care Act for Young Carers	
Assessment	Review	Safeguarding	Support Planning
Will this person have substantial difficulty in being involved with the process?		Yes	No
Has the client been deemed as having no appropriate person to facilitate the client's engagement in the process?		Yes	No

Independent Mental Capacity Advocacy (IMCA) age 16+ please complete all sections to enable us to triage the referral

Serious Medical Treatment	Change in Accommodation	Safeguarding
Care Review		
Has the client been assessed as lacking capacity around this issue?	Yes	No
Has the client been deemed to not have appropriate friends or family who can be consulted?	Yes	No
Date of capacity assessment:		
Who completed the capacity assessment?		
Any upcoming meeting dates?		
Has the client been deemed to not have appropriate friends or family who can be consulted?	Yes	No

Independent Mental Health Advocacy (IMHA) age 16+ - please complete all sections to enable us to triage the referral

Section 2	Section 3	CTO	Guardianship	Other: _____
Section start date:				
Ward:				
Any upcoming meeting dates?				
Referral Reason				
Additional Professionals - Contact Details				