Blackburn with Darwen Advocacy Hub

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## CONFIDENTIAL

## CHILDREN & YOUNG PERSONS FORM

| | | | |
|---|---|---|---|
| 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 ☐ | | |

| | |
|---|---|
| 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? | ☐ Yes ☐ No |
| Signature of referrer: | |

| | |
|---|---|
| Gender: | ☐ Male ☐ Female ☐ Prefer not to say<br>☐ Female, male at birth ☐ Male, female at birth ☐ Other, please specify<br>☐ Non-binary |
| Pronouns: | ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____ |
| Sexual Orientation: | ☐ Asexual ☐ Bisexual ☐ Heterosexual<br>☐ Gay/Lesbian ☐ Prefer not to say ☐ Other, please specify _____ |
| Disability: | ☐ Acquired brain injury ☐ Multiple impairments ☐ Neurological conditions<br>☐ Carer ☐ Older person ☐ Physical disability<br>☐ Dementia ☐ Sensory impairment ☐ Stroke<br>☐ Long term health condition ☐ Substance misuse ☐ Other (please specify)<br>☐ Autism ☐ Learning disability _____<br>☐ Communication difficulties ☐ Mental health |

| | |
|---|---|
| Ethnic Origin: | ☐ African ☐ Arab/British Arab ☐ Asian/British Asian<br>☐ Black/Black British ☐ Carribean ☐ Chinese<br>☐ European ☐ Gypsy/Roma ☐ Indian<br>☐ Mixed heritage ☐ Pakistani ☐ White British<br>☐ White Irish ☐ White other ☐ Prefer not to say<br>☐ Other, please specify: _____ |

| | | | |
|---|---|---|---|
| Religion: | ☐ Atheist<br>☐ Catholic<br>☐ Christian<br>☐ Jewish | ☐ Sikh<br>☐ Buddhist<br>☐ Hindu<br>☐ Muslim | ☐ Jehovah Witness<br>☐ Not known<br>☐ No religion<br>☐ Other, please specify:<br>_____ |

## 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: | |

## Upcoming meetings

| Are there any upcoming meetings that we need to be aware of?<br>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 : | ☐ Child in Need Plan / Section 17<br>☐ Child Protection / Section 47 Enquiry (ICPC)<br>☐ Looked after Child/ Section 20<br>☐ Child Protection Plan / Section 47<br>☐ Interim Care Order<br>☐ Full Care Order | ☐ Care Leaver (Post 18)<br>☐ 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) - please complete all below sections for us to be able to triage the referral**

| | | | |
|---|---|---|---|
| Serious Medical Treatment ☐ | Change in Accommodation ☐ | Safeguarding ☐ | |
| Care Review ☐ | Rule 1.2 Rep ☐ | CoP DoL paperwork attached ☐ | |
| 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? | | | |

| Referral Reason |
|---|
| |

| Additional Professionals - Contact Details |
|---|
| |

**Please return this form to -**
Email: **referral@bwdadvocacyhub.org.uk** Phone: **033 000 222 00**
Post: **BwD Advocacy Hub n-compass, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF**
Website: **www.blackburnwithdarwenadvocacyhub.org.uk**

Blackburn with Darwen Borough Council