**Advocacy Self - Referral Form – Bath & North East Somerset residents**

**Swan Advocacy supports clients in need of advocacy, who are over 18 and resident in B&NES**

**PLEASE NOTE:**

**Swan Advocacy can only accept a referral if the person needing an advocate has given their consent.**

***Please complete all sections otherwise the referral will be returned to you and will delay the referral being processed; this includes the monitoring questions at the end of the form.***

|  |  |  |
| --- | --- | --- |
| Are you asking for an advocate for yourself? Yes /No | | If Yes, how did you hear of Swan? |
| **Your information** | | |
| Name: | Date of birth: | |
| Address at point of referral (eg. Hospital)  Postcode:  Phone no at point of referral: | **Please tick your Primary Vulnerability:**   * Mental Health Needs – Client **MUST** have significant MH needs so please describe \_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Learning Disability * Older Person (Over 60) * Physical Impairment * Acquired Brain Injury * Dementia * Carer * Autistic Spectrum Disorder * Sensory Impairment * Other (please state) | |
| Home address (if different from above):  Postcode:  Home phone no: |
| **Are you:**   * In receipt of, or disputing access to, secondary services?      * In receipt of, or disputing access to, Disability Living Allowance/Personal Independence Payment? * Providing unpaid care for an adult in receipt of the above services? | | **Are you:**   * Detained under MHA Sec 2\_\_\_/Sec 3\_\_\_ * Subject to a CTO * Subject to a Guardianship Order * Subject to a restricted conditional discharge * Considered for Section 57 Treatment * Under 18 & considered for ECT * Under 18 and considered for Sec 58A |
| Do you have any special needs we should consider when visiting, or arranging to meet with them, (eg. do you have difficulty in communicating verbally/in writing?) | | |
| Are there any risks that we should be aware of when visiting or arranging to meet with you (including those posed by others?) | | |
| During the advocacy process will you have difficulty communicating their views and feelings/ have difficulty retaining information/understanding information/weighing up the information? | | |
| **Please state briefly what you feel the advocacy issue to be:** | | |
| **Are there any deadlines or important meeting dates?** | | |
| **CONSENT Due to the Data Protection Act 1998, we need signed authorisation to say that you agree to Swan Advocacy holding personal information (including the information provided on this referral)** | | |
| **Signed Date** | | |

**The information on this page is required for service monitoring purposes only**

**but is a compulsory section of this referral form**

**Please tick as appropriate**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Ethnic Origin** | | **Client’s Religion or Belief** | | | | **Language** | | | |
| White British |  | Bahi | | |  | What is your first language? | |  | |
| Any other white background |  | Buddhism | | |  |  | |  | |
| Black/African/Caribbean |  | Christianity | | |  |  | |  | |
| Mixed and Multiple ethnic groups |  | Hinduism | | |  |  | |  | |
| Asian |  | Humanism | | |  |  | |  | |
| Other ethnic Group |  | Islam | | |  |  | |  | |
| Prefer not to say |  | Judaism | | |  |  | |  | |
|  |  | Paganism | | |  |  | |  | |
|  |  | Sikhism | | |  |  | |  | |
|  |  | Other | | |  |  | |  | |
|  |  | Prefer not to say | | |  |  | |  | |
|  |  |  | | |  |  | |  | |
|  |  |  | | |  |  | |  | |
| **Gender** | | | | | | | | | |
| **Do you identify;-** |  | **Does your gender identity match completely the sex you were registered at birth?** | | **Sexual Orientation** | | | | |  |
| As a woman |  | Bisexual | | | | |  |
| As a man |  | Gay | | | | |  |
| In some other way |  | Yes |  | Heterosexual | | | | |  |
| Prefer not to say |  | No |  | Lesbian | | | | |  |
|  |  | Prefer not to say |  | Other | | | | |  |
|  |  |  |  | Prefer not to say | | | | |  |
|  |  |  | |  | | | | | |
|  |  |  | |  | | | | | |
| **Carers** | | | | | | | | | |
| Do you provide care for anyone (eg a parent, child, other relative, an elderly person, friend or neighbour) who has a form of disability (sensory loss, physical, learning disability, mental health problem) long or terminal illness? | | | | | | | Yes | |  |
| No | |  |
| Prefer not to say | |  |