**Generic Advocacy Referral Form – Bath & North East Somerset residents**

**Swan Advocacy supports clients in need of generic 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? |
| If you are asking for an advocate for someone else, have they given their consent?  |
| May we contact the client directly? Yes/No If no, whom should we contact?  |
| **Referrer Information (if other than the client)** |
| Full name:  | Job Title (If appropriate) Independent Advocate Swan Advocacy  |
| Address: Postcode:  | Telephone No: Email Address:  |
| Relationship to Client; |
| **Client information (the client is the adult who is in need of an advocate)** |
| Name:  | Date of birth:  |
| Address at point of referral (eg. Hospital) Postcode**:** Phone no at point of referral:  | **Please tick any vulnerability of person being referred;*** Mental Health Needs – Client **MUST** have significant MH needs so please describe \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Older Person (over 60)
* Physical Impairment
* Acquired Brain Injury
* Mental Health Needs – Please
* Dementia
* Carer
* Autistic Spectrum Disorder
* Sensory Impairment
* Other (please state)
 |
| Home address (if different from above):Postcode:Home phone no:Email Address: |
| **Is the client:*** **In receipt of, or disputing access to, secondary services? No**
* **In receipt of, or disputing access to, Disability Living Allowance/Personal Independence Payment? No**
* **Providing unpaid care for an adult in receipt of the above services? Yes**
 |
| **Does the client have any special needs we should consider when visiting, or arranging to meet with them, (eg. do they have difficulty in communicating verbally/in writing?)**  |
| **Are there any risks that we should be aware of when visiting or arranging to meet with the client** eg. Pets at the home, Substance/Tobacco use, Behavioural issues, Neighbourhood concerns, Risk of self harm/Suicide, other members of the household |
| **During the advocacy process will the client 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? A further best interests meeting will need to be arranged asap**  |
| **CONSENT Due to the Data Protection Act 1998, we need signed authorisation to say that the individual agrees to Swan Advocacy holding personal information (including the information provided on this referral)**NB If an electronic signature isn’t used, the return of this form is a presumption of a signature |
| **Signed Referrer Signed Client** **Date;** |

**Where referrals are made by a third party – written contact with the client will be made within 3 working days of receipt of this form, though it may take longer to allocate an advocate.**

**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 |  |  |  |
|  |  | Not Asked |  |  |  |
|  |  |  |  |  |  |
| **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 |  |