**Advocacy Self - Referral Form – South Gloucestershire residents**

**SWAN supports clients in need of advocacy, who are over 18 and resident in South Glos**

**PLEASE NOTE:**

**SWAN 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:*** Learning Disability
* Older Person (Over 60)
* Physical Impairment
* Acquired Brain Injury
* Mental Health Needs, please describe;
* Significant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Low Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dementia
* Carer
* Autistic Spectrum Disorder
* Sensory Impairment
* Significant grief or distress
* Long term health condition
* Chaotic Lifestyle
 |
| Home address (if different from above):Postcode:Home phone no:Email Address: |
| **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 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 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 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 |  |