**Independent Mental Health Advocacy Referral Form – Pan Dorset**

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| **NB: SWAN can only accept a referral if the person needing an advocate has given their consent. If you believe they do not have the capacity to consent, please give brief details on the ‘additional information’ section of this form.** ***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? [ ]  Yes [ ]  No |
| If you are asking for an advocate for someone else, please complete the ‘Client information’ and ‘Referrer information’ sections of this form. |
| May we contact the client directly?[ ]  Yes [ ]  No | If no, who should we contact? |
| **Referral Information (if other than the client)** |
| Full Name:  | Job Title (if appropriate):  |
| Address: | Telephone No:  |
|  | Email Address:  |
| Postcode:  | Relationship to Client:  |
| **Client Information (the client is the adult needing an advocate)** |
| Full Name:  | Date of Birth: DD/MM/YYYY |
| Address at point of referral (e.g. hospital): | Home address (if different): |
| Postcode:  | Postcode:  |
| Phone no. at point of referral:  | Home phone no: |
| Email address: |  |
| **Is the client:** (please indicate eligibility) |
|[ ]  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 |
| **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?**  |
|  |
| **Please state any pertinent information about the client:** Any information will be shared with the client unless the client is deemed not to have the capacity to instruct. |
|  |
| **In making this referral, I declare that:** * **I wish to request advocacy support from South West Advocacy Network (SWAN).**
* **I understand that client information supplied on this form will be stored safely on SWAN’s system.**
* **I confirm that I am either a self-referring client or I have consent from the client to make the referral, or I have the authority to make the referral for the client.**

By requesting advocacy support, you give consent to SWAN sharing information where necessary for the purpose of providing this service. All data held by SWAN is held in accordance with the current UK General Data Protection Regulations legislation. |

**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** |
| White British |[ ]  Bahi |[ ]
| Any other white background |[ ]  Buddhism |[ ]
| Black/African/Caribbean |[ ]  Christianity |[ ]
| Mixed or 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** |
| **Is your gender the same as assigned at birth?** | **Do you identify:** | **Sexual Orientation** |
|  |  | Heterosexual |[ ]
| Yes |[ ]  As a woman |[ ]  Gay |[ ]
| No |[ ]  As a man |[ ]  Bisexual |[ ]
| Prefer not to say |[ ]  In another way |[ ]  Lesbian |[ ]
|  | Prefer not to say |[ ]  Other |[ ]
|  |  | Prefer not to say |[ ]
|  |  |  |  |
| **Carers** |
| Do you provide care for anyone (e.g. 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 term health issues or terminal illness? | Yes |[ ]
|  | No |[ ]
|  | Prefer not to say |[ ]