**Parents Advocacy Referral Form – Pan Dorset**

|  |  |
| --- | --- |
| 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 | |
| May we contact the client directly?  Yes  No | If no, who should we contact? |
| **Referrer 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 |
| Location at point of referral (e.g. hospital): | Home address (if different): |
| Postcode: | Postcode: |
| Phone no. at point of referral:  Mobile No. | Home phone no:  Mobile No. |
| Email address: | |
| **Does the client have any special needs we should consider when visiting, or arranging to meet with them?** (e.g. 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 indicate which area of LA the Parents with Learning needs referral is from:  Referral from Adults services  Referral from Childrens services | |
|  | |
| **Please state what you feel the advocacy issue to be:** | |
|  | |
| **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. | |

**Where referrals are made by a third party – written contact with the client will be made within 2 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** | | | | | | |
| 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 | | |  |