**SWAN IMHA Advocacy Referral Form Children & Young People**

**CYP**

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| **To check eligibility for a referral into the service for an IMHA please click on the link below:**<https://swanadvocacy.org.uk/services/advocacy-services/>*Kindly ensure all sections of the referral form are completed, as incomplete forms may be returned and could delay your referral.* |
| **Are you asking for an advocate for yourself?** |[ ]  Yes |[ ]  No |
| **If you are asking for an advocate for someone else, have they given consent?** |[ ]  Yes |[ ]  No |
| **May we contact the child directly?** |[ ]  Yes |[ ]  No |
| **If not, then whom should we contact?** |  |
| **Child/Young Person’s Details***(the child is the child or young person needing an advocate)* |
| **Name:** |  |
| **Preferred Name:** |  |
| **Pronouns:** |  |
| *(if known)* |
| **Address at Point of Referral:** *(if hospital please include ward name)* |
|  |
| **Postcode:** |  |
| **Telephone No.** |  |
| **Home Address:** *(if different)* |
|  |
| **Postcode:** |  |
| **Date of Birth:** | DD/MM/YYYY | **Sexual Orientation:** | Sexual Orientation |
| **Ethnicity:** | Ethnicity | **Religion:** | Religion | **Gender:** | Gender |
| **Is their gender the same as assigned at birth?** | [ ]  Yes | [ ]  No | [ ]  Prefer not to say |
| **Do they have any disabilities:** *(please tick all that apply)* |
|[ ]  Chronic or long-term condition |[ ]  Learning disability |[ ]  Mental illness |
|[ ]  Chronic or long-term pain |[ ]  Memory |[ ]  Mobility |
|[ ]  Hearing |[ ]  Neurodivergent |[ ]  Neurological condition |
|[ ]  Speech or language |[ ]  Stamina, breathing or fatigue |[ ]  Vision |
|[ ]  Other |[ ]  Prefer not to say |
| **If other, please specify:** |  |
| **Child’s legal status:** | Choose an item. |
| **Date child became looked after:** | DD/MM/YYYY |
| **Resident Local Authority:** | Choose an item. |
| **If other, please state Local Authority:**  |  |
| **Does the child have a Child Protection Plan?** |[ ]  Yes |[ ]  No |
| **Additional information or comments relating to any of the above:** |
|  |
| **Any vulnerabilities we should consider when visiting, contacting or arranging to meet with them?**(e.g. do they have difficulty in communicating verbally/in writing, mental health issues, substance use etc.) |
|  |
| **Are there any risks that we should be aware of when visiting or arranging to meet the child?** |
|  |
| **Any communication needs:** |  |
| **Referral Details** |
| **Support required for:** *(please indicate eligibility)* |
|[ ]  Detained under MHA Sec 2\_\_/Sec 3 \_\_ |
|[ ]  A voluntary patient under consideration for ECT |
|[ ]  Child subject to a Community Treatment Order (CTO) |
|[ ]  Child subject to Sections 27, 47, 48 or 49 (Crime Committed) |
|[ ]  Other |
| If other, please specify: |  |
| **Any key information and/or key dates:** |
|  |
| **Referrer Details** |
| **Full Name:** |  | **Job Title:** |  |
| **Address**: | **Team:** |  |
|  | **Tel:** |  |
| **Postcode:** |  | **Email:** |  |
| **Child/Young Person’s Parent/Primary Details** |
| **Is the parent/primary carer aware of this referral?** |[ ]  Yes |[ ]  No |
| **Name:** |  |
| **Address:**  |
|  |
| **Postcode:** |  |
| **Telephone Number:** |  |
| **Email Address:** |  |
| **Child/Young Person’s Social Worker Details***(if different from above)* |
| **Full Name:** |  | **Job Title:** |  |
| **Address**:  | **Team:** |  |
|  | **Tel:** |  |
| **Postcode:** |  | **Email:** |  |
| **School/College Details** |
| **Full Name:** |  | **Job Title:** |  |
| **Address**: | **Team:** |  |
|  | **Tel:** |  |
| **Postcode:** |  | **Email:** |  |
| **In making this referral, I declare that:** * **I wish to request advocacy support from South West Advocacy Network (SWAN).**
* **I understand that child information supplied on this form will be stored safely on SWAN’s system.**
* **I confirm that I have consent from the child to make the referral or have consent from the child’s parent/carer, or I have the authority to make the referral for the child.**
* **I confirm that the child understands that they are sharing information about them, including data about their health, race/ethnicity and this may be shared as part of this referral.**

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. |
| **What happens next?****Email this form to** **eastsussex@swanadvocacy.org.uk****Acknowledgment** – You will receive confirmation of receipt of your referral within a few hours, this will contain a case number. If you have not received this by the next working day, please contact us. **Review** – We will check the referral includes all the information that we require. **Clarify** – If there is any missing information, issues about eligibility, etc we will contact you and request this. **Allocate** – As soon as we have all of the information we need, we will allocate and provide the contact details of who has been assigned, and you can liaise with them directly. |