**SWAN Rule 1.2 Advocacy Referral Form Children & Young People**

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| ***The current care and support plan and draft COP11 (if available) should be attached to this referral.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child/Young Person’s Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Name:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address at Point of Referral:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Postcode:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone No.** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Home Address:** *(if different)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | |
| **Any communication needs:** | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Details of Relevant Professionals** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | | | | | **Email Address:** | | | | | | | | | | | | | | | | | | | | | **Connection to Client:** | | | | | | | | | | | |
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| **Capacity Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the child been formally assessed to lack capacity?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | | | No |
| **A decision specific capacity assessment was completed on:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DD/MM/YYYY | | | | | | | | |
| **Name of Assessor:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | **Job Title:** | | | | | | |  | | | | | | | | | | | | | |
| **Any key information and/or key dates:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Please briefly state the advocacy requirement:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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:** | | | | |  | | | | | | | | | | | | | | | | | |
| **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.** * **I confirm the child is living somewhere other than a residential home or hospital** * **I confirm the child is not free to leave and is subject to complete or continuous supervision and control** * **I confirm the child has been assessed as lacking capacity to consent to this** * **I confirm the child does not have a friend or family member who can take on the role.** * **I confirm the child’s current care plan and draft COP11 are attached with this referral form.**   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**](mailto: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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |