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| **Referral Form****Three County Independent Professional Advocacy Service** |
|  | E-MAIL: info@cipawales.org.ukFreephone number: 0800 206 1387 |
| Name of person being referredTitle: Miss / Mrs / Ms / Mr / Other -  | Full Name: **Preferred Name:**  |
| Home Address:   |  | **CONTACTS**: Mobile: Landline: Email:  |
| Communication Preference: Circle all that apply  |  Email |  Phone  |  |
|  Text |  Post |
| Date of Birth: |  |
| **Communication requirements or preferences:** Welsh, English, other spoken language, British Sign Language, Easy Read, non-verbal communication, communication aids (please specify those that apply): |
| **What is your relationship with the client?** **Has the client consented to the referral? Yes**  **No** (Referrals for clients with capacity to instruct an advocate should only be made with the consent of that person)**Does client lack capacity to consent to referral? Yes No** If client lacks capacity to consent, is referral made in the person’s best interests? Yes No  |
| **Does the client have social care and support needs?** Yes No**Does the client care for someone who has social care and support needs?** Yes No**Information about client’s social care and support needs:** |
| **Is the client/someone they care for undergoing:**An assessment Care and support planning A review A safeguarding enquiry or safeguarding review Complaints about the above **What barriers are there to prevent them from participating fully in this?****Is there anyone else who can advocate for the client?** Yes No |
| **Reason for referral:** (Please include dates/details of any forthcoming deadlines or meetings) |
| **Any other relevant information** (including any information required to keep the person and/or the advocate/others safe): |
| **How did you hear about our service?** |
| Referred by: |   | Referral date:  |
| Position: |   | Tel no of referrer:  |
| Signature: |  | Email of referrer:  |