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| **Self-Referral Form**  **Three County Independent Professional Advocacy Service** | | | | | |
|  | | | E-MAIL: info@cipawales.org.uk  Freephone number: 0800 206 1387 | | |
| Title: Miss / Mrs / Ms / Mr / Other - | | | | Name:  **Name I’d like you to use:** | |
| Home Address: |  | | | | **CONTACTS**:  Mobile:  Home phone:  Email: |
| Please contact me by  (Circle all that apply) | Email | Phone | | |  |
| Text | Post | | |
| Date of Birth: |  | | | | |
| Do you want us to talk to you in Welsh/English?  Do you have any other needs (like Easy Read, BSL etc)? | | | | | |
| Do you have social care and support needs? Yes No  Do you care for someone who has social care and support needs? Yes No  If you care for someone, what is your relationship to them:  Information about your social care and support needs/the needs of the person you care for: | | | | | |
| Are you/someone you care for undergoing:  An assessment Care and support planning  A review A safeguarding enquiry or safeguarding review  Complaints about the above  What makes it hard for you to get involved in this?  Is there anyone else who can advocate for you? Yes No | | | | | |
| Reason for contacting us: | | | | | |
| Any other information **(including any information required to keep you and/or the advocate/others safe):** | | | | | |
| How did you hear about us? | | | | | |
| Referral Date |  | | | | Signature: |