# Children’s advocacy referral form

## For referrals from professionals

#### *Text field boxes will expand as you type.*

#### *All data supplied to us in this form will be processed in accordance with our* [*Privacy Notice*](https://www.voiceability.org/privacy-policy/)*.*

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| 1. Reason for child or young person’s advocacy referral |
| **Please describe the reason you are requesting advocacy support:** (this box will expand as you type) |
| **Please tell us the names and contact details of any professionals, other than yourself, who are currently working with the child or young person:** |
| **Please tell us the name and contact details of the child or young person’s parent or guardian:** |
| **Please tell us the name and contact details of the foster carer(s) if applicable:** |
| **Please tell us about the child or young person’s school, college or work, if applicable, and how to contact them:** |

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| **2. Details of the person you are referring** | | | | | | | | | | |
| **First name** |  | | | | **Last name** |  |  | | | |
| **Date of birth** |  | | | | | | | | | |
| **Current address and postcode** *(if hospital, please include ward name)* |  | | | | | | | | | |
| **Home address and postcode** *(if different to current address)* |  | | | | | | | | | |
| **Email** |  | | | | | | | | | |
| **Phone number** |  | | | | | | | | | |
| **Are you supporting a Looked After Child?** | | | | | Yes  No  If **Yes**, then select their status below.  If **No,** then skip to ‘Conditions or disabilities’ | | | | | |
| Leaving care | |  | | | Has a complaint | | |  | | |
| Going through Child Protection proceedings  *(not covered by us in Suffolk)* | |  | | |  | | |  | | |
| **What conditions or disabilities does the person you’re referring have?** *(Please select all that apply)* | | | | | | | | | | |
| Learning disability | | |  | | Sensory impairment | | |  | | |
| Acquired brain injury | | |  | | Long term health condition | | |  | | |
| Autistic spectrum diagnosis | | |  | | Substance misuse/addiction | | |  | | |
| Mental health condition | | |  | | None | | |  | | |
| Neurological conditions | | |  | | Other *(please specify)* | | |  | | |
| Stroke | | |  | | Further details | | | | | |
| Physical disability | | |  | |
| **Does the person have any access needs, for example communication or physical needs?** *(Please select all that apply)* | | | | | | | | | | |
| They need an interpreter | | | |  | They have physical access needs | | | | |  |
| They use Makaton | | | |  | They do not use the telephone | | | | |  |
| They use British Sign Language (BSL) | | | |  | They prefer information written down | | | | |  |
| They use assistive communication (e.g. Symbol book, Talking Mats, PECS) | | | |  | Other *(please specify)* | | | | | |
| They are non-verbal | | | |  | Further details | | | | | |
| They prefer information in Easy Read | | | |  |  | | | | | |
| **Has the person you’re referring requested an advocate?** | | | | | Yes  No | | | | | |
| **If yes, do they require a same-gender advocate?**  *(i) We always try to meet same-gender requests but are not always able to do this, depending on availability.* | | | | | | | | Yes  No  Don’t know | | |
| **Has the person agreed to this referral?**  *(i) If capacity fluctuates then they should be asked about agreeing to a referral when they have capacity* | | | | | | | | Yes  No  Lacks capacity | | |
| **What meetings does the advocate need to attend?**  *(i) Please provide the title of the meeting and the date. You can add multiple meetings.*  **Names and dates of meetings** | | | | | | | | | | |
| **Is there anything we need to know in order to ensure the safety of the person you are referring and of our advocates?** *(Please select all that apply)* | | | | | | | | | | |
| 2 to 1 or higher support ratio | | |  | | Other *(please specify)* | | | |  | |
| Daily change in risk profile | | |  | | Further details | | | | | |
| History of abuse/​assault of professionals | | |  | |
| **If your organisation has a reference number for the person, you must provide it here**  *(i) For example, Mosaic, Care Direct, NHS or prison number* | | | | |  | | | | | |
| ***For referrals to our Coventry and Warwickshire team only*** If you are referring someone who does not live in Coventry or Warwickshire but is registered at a GP surgery in Coventry or Warwickshire, please tick here:  Coventry GP  Warwickshire GP | | | | | | | | | | |

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| Diversity monitoring | | | | |
| *We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the person you’re referring, you can help us improve what we offer.* | | | | |
| What is the gender of the person you’re referring? | | | Is this different from their gender assigned at birth? | |
| Male |  | | Yes |  |
| Female |  | | No |  |
| Non-binary |  | | Don’t know/prefer not to say |  |
| Other |  | |  |  |
| Don’t know/prefer not to say |  | |  |  |
| What is their sexual orientation? | | | | |
| Heterosexual/​straight |  | | Gay woman/​lesbian |  |
| Bisexual |  | | Don’t know/​prefer not to say |  |
| Gay man |  | | They prefer to self-describe *(please specify)* |  |
| **What is their ethnic group?** | | | | |
| *Asian or Asian British* | | | | |
| Bangladeshi | |  | Pakistani |  |
| Chinese | |  | Another Asian background |  |
| Indian | |  | Don’t know/​prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | |
| African | |  | Another Black background |  |
| Caribbean | |  | Don’t know/​prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | |
| Asian and White | |  | Another Mixed background |  |
| Black African and White | |  | Don’t know/​prefer not to say |  |
| Black Caribbean and White | |  |  |  |
| *White* | | | | |
| British, English, Northern Irish, Scottish, or Welsh | |  | Another White background |  |
| Irish | |  | Don’t know/​prefer not to say |  |
| Irish Traveller or Gypsy | |  |  |  |
| *Another ethnic group* | | | | |
| Arab | | |  | |
| Another ethnic background | | |  | |
| Prefer not to say | | |  | |
| Don’t know/​prefer not to say | | |  |  |
| **What is their religion?** | | | | |
| No religion | |  | Christian (all denominations) |  |
| Buddhist | |  | Hindu |  |
| Jewish | |  | Muslim |  |
| Sikh | |  | Other (please state) | |
| Don’t know/​prefer not to say | |  |  | |

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| **3. Your details** | | | | | | | |
| **Title** | |  | | | | | |
| **Full name** | |  | | | | | |
| **Email address** | |  | | | | | |
| **Organisation** | |  | | | | | |
| **Work address** | |  | | | | | |
| **Team or department** | |  | | | | | |
| **Profession** | | Doctor | |  | Nurse | |  |
| Dentist | |  | Other health professional | |  |
| Support worker | |  | Social worker | |  |
| Lawyer | |  | Manager | |  |
| Police | |  | Other | |  |
| **Job title (if different)** | |  | | | | | |
| **Phone number we can contact you on if we have questions about this referral** | |  | | | | | |
| **Mobile phone number (if different)** | |  | | | | | |
| **Would you like to join our email newsletter?** | | Yes, please add my email to the mailing list  No, I’d prefer not to be added to the mailing list | | | | | |
| **Is this the first time you have made a referral to VoiceAbility?** | | Yes  No | | | | | |
| **If yes, please tell us how you heard about us.** *(Please select all that apply)* | | | | | | | |
| Word of mouth |  | | Social media | | |  | |
| Online search |  | | Presentation/​training | | |  | |
| Leaflet or poster |  | |  | | |  | |
| Other (please specify) |  | | | | | | |

**Please email the completed form to** [**helpline@voiceability.org**](mailto:helpline@voiceability.org)**.**

If you are emailing this form from Warwickshire, Coventry or a prison in Doncaster, you must email using an approved secure method. For more information, go to   
[**voiceability.org/about-advocacy/advocacy-referral-forms**](http://www.voiceability.org/about-advocacy/advocacy-referral-forms)

**Alternatively, you can post the form to Unit 1, The Old Granary, Westwick, Oakington, Cambridge, CB24 3AR**