|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A picture containing clipart  Description automatically generated** | | | **General Advocacy Service  Referral Form** | | | | | | | | | | | | | | | | |
| * General advocacy is also known as **non-statutory advocacy**. It means any kind of advocacy that is not required by law. * General advocacy referrals can be made by professionals (with the individual’s permission) and by individuals who wish to self-refer. | | | | | | | | | | | | | | | | |
| Please **complete this form fully**, including the equalities information. If the form is not fully completed this may delay the appointment of an advocate.  If you need help or have questions, please contact our office on **0191 478 6472** or freephone **0800 048 7856** | | | | | | | | | | | | | | | | | | | |
| **Text field boxes will expand as you type** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Section 1: Referral Information** | | | | | | | | | | | | | | | | | | | |
| **1.1 About the person** | | | | | | | | | | | | | | | | | | | |
|  | **Reference number for the person** *(i.e. Mosaic, Care Direct, NHS):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **First name:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Last name:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Preferred pronouns** *(i.e. She, He, They):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Date of birth** *(DD/MM/YYYY):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Home address:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Postcode:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Address at time of referral** *(if different to above & including ward if relevant):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Postcode:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Person’s contact information** | | | | | | | | | | | | | | | | | |  |
|  | Mobile: | | | | | | |  | | | | | Landline: | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | Can we Text? - Select - | | | | | | | |  | | | | | Leave voicemails? - Select - | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | Send email? - Select - | | | | | | | | |  | | | | Email: | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| **Section 2: Referral Reason** | | | | | | | | | | | | | | | | | | | |
| **2.1 Reason for general advocacy referral?** | | | | | | | | | | | | | | | | | | | |
|  | **Summary of the situation that requires general advocacy support:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Key people** *(include relationship and contact information):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Is the person being discharged from hospital?** | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | |  | | | | Discharge date: | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| **Section 3: Access Information** | | | | | | | | | | | | | | | | | | | |
| **3.1 Communication and Accessibility** | | | | | | | | | | | | | | | | | | |  |
|  | **Preferred Language:** | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | |  | | | | Other: | | | | |  |
|  | **Communication and Access needs** *(please tick all that apply):* | | | | | | | | | | | | | | | | | |  |
|  | Able to read | | | |  | | | | | | Hearing impaired | | | | | | |  |  |
|  | Braille | | | |  | | | | | | Large print | | | | | | |  |  |
|  | British Sign Language | | | |  | | | | | | Manual alphabet | | | | | | |  |  |
|  | Easy Read | | | |  | | | | | | Minicom | | | | | | |  |  |
|  | English is a second language (ESL) | | | |  | | | | | | Moon | | | | | | |  |  |
|  | Gestures/expressions/vocalisations | | | |  | | | | | | No formal means of communication | | | | | | |  |  |
|  | Pictures/Symbols/Makaton | | | |  | | | | | | Other: | | | | | | | |  |
|  | **Support from interpreting services** *(i.e. spoken language, BSL):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Requires a same gender advocate:** | | | | | | | | | | | | | | | | | |  |
|  |  | *(we will always try to meet same-gender requests but are not always able to do this, depending on availably)* | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| **Section 4: Referrer Information** | | | | | | | | | | | | | | | | | | | |
| **4.1 Your Information** | | | | | | | | | | | | | | | | | | | |
|  | **Full name:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Organisation:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Work address:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Team or department:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Contact information** | | | | | | | | | | | | | | | | | |  |
|  | Mobile: | | | | | | | |  | | | | | Landline: | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | Email: | | | | | | | | | | | | | | | | | |  |
|  | **Profession** | | | | | | | | | | | | | | | | | |  |
|  | Social worker | | |  | | | | | | | Dentist | | | | | | |  |  |
| Doctor | | |  | | | | | | | Other health professional | | | | | | |  |
| Nurse | | |  | | | | | | | CHC case worker | | | | | | |  |
|  | Not listed, please specify: | | | | | | | | | | | | | | | | | |  |
|  | **Job title** *(if different to above):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | **Would you like to join our email newsletter?** | | | | | | | | | | | | | | | | | |  |
|  | Yes, please add my email to the mailing list | | | | | | | | | | | |  | |  | No, thanks |  | |  |
|  | **Is this the first time you have made a referral to Your Voice Counts Advocacy?** | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | | | | | | | | | | |  |
|  | **Please tell us how you heard about us** *(Please tick all that apply):* | | | | | | | | | | | | | | | | | |  |
|  | Word of mouth | | | | |  | | | | | Online search | | | | | | |  |  |
|  | Leaflet of poster | | | | |  | | | | | Social media | | | | | | |  |  |
|  | Awareness raising/training provided by Your Voice Counts | | | | | | | | | | | | | | | | |  |  |
|  | Not listed, please specify: | | | | | | | | | | | | | | | | | |  |
| **4.2 Risk** | | | | | | | | | | | | | | | | | | | |
|  | **Please tell us about any risk issues or incidents relevant to the person we should be aware of** *(tick all that apply, you must tick at least one box):* | | | | | | | | | | | | | | | | | |  |
|  | No risk identified | | | | | |  | | | | | Risk of harm due to medication/medical condition | | | | | |  |  |
|  | Risk of deliberate self-harm | | | | | |  | | | | | Risk of suicide | | | | | |  |  |
|  | Risk of severe self-neglect | | | | | |  | | | | | Risk of domestic violence/abuse | | | | | |  |  |
|  | Risk of adult abuse | | | | | |  | | | | | Risk of violence/harm to others | | | | | |  |  |
|  | Risk to a child | | | | | |  | | | | | Risk to staff | | | | | |  |  |
|  | Risk of exploitation | | | | | |  | | | | | Risk of radicalisation | | | | | |  |  |
|  | **Please provide details of any known risks that professionals need to be aware:** | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
| **4.3 Other** | | | | | | | | | | | | | | | | | | | |
|  | **Timescales and key dates** *(i.e. date of upcoming meetings):* | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |

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| **Section 5: Equality and Diversity** | | | | | |
| We collect the information in this section to help us shape our services to represent the needs of our communities. This information is known as **‘equality monitoring data’** and helps us to create equality of access and opportunity and helps us to improve the services that we provide.  We will keep this information confidential and will only use it anonymously.  If you are referring someone, please discuss how they describe themselves and complete. | | | | | |
|  | **What conditions or disabilities does the person have?** *(please tick all that apply):* | | | |  |
|  | Learning disability |  | Sensory |  |  |
|  | Autism |  | Stroke |  |  |
|  | Mental health |  | Cancer |  |  |
|  | Drug/alcohol misuse |  | Heart condition |  |  |
|  | Elderly/frail |  | No long-term health condition |  |  |
|  | Alzheimer’s/Dementia |  | Other physical illness or disability |  |  |
|  | Other describe: | | | |  |
|  | **Gender:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  |  | | | |  |
|  | **Sexual orientation:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  | **Ethnic origin:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  | **Religion or belief:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  | | | | | |

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| --- | --- | --- |
| **Section 6: Data Protection** | | |
| **General Data Protection Regulations**  **Statement:** Your Voice Counts is committed to processing information in accordance with the General Data Protection Regulations (GDPR). The personal data collected on this form will be held securely and will only be used for the purposes of providing independent advocacy. We will hold the data for 6 years.  You can use the below contact details if you have any questions about this form, the way we are planning to use the information on the form, the lawful basis for processing the information on the form, or any queries relating to data protection.  **Contact details:**  Jenny Rohde (Head of Operations) [jenny.rohde@yvc.org.uk](mailto:jenny.rohde@yvc.org.uk) | | |
|  | **Signature of person making the referral:** |  |
|  |
| **Date of referral:** |
|  |
|  |
| If you need support to complete this form you can get in touch by phone, email, or through our website.  Our office **0191 478 6472** or freephone **0800 048 7856**  **Please email the completed form to** [**yvc.uk@nhs.net**](mailto:yvc.uk@nhs.net)  Alternatively, you can post the form to Your Voice Counts, Greensefield Business Centre, Mulgrave Terrace, Gateshead, NE8 1PQ  **We will contact you within 2 working days of receipt of your referral**  Logo  Description automatically generated | | |