Children & young people receiving social care services, have a right to access independent advocacy. An advocate can help a child or young person make a complaint or support them to have their views heard in meetings where decisions are being made about them.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Child or Young Person’s Details | | | | | | |
| Name |  | | | Known as |  | |
| Date of birth |  | | | Gender |  | |
| Ward / Address of current location |  | | | | | |
| postcode |  | | | Telephone no. |  | |
| Staff contact name at current address if applicable | |  | | | | |
| Home address (if different from above) |  | | | | | |
| postcode |  | | | Telephone no. |  | |
| Religion or spiritual beliefs |  | | | | | |
| Ethnicity | White British | | White Irish | | | White Gypsy / Irish Traveller |
| Other White background | | Black / Black British African | | | Black / Black British Caribbean |
| Other Black background | | Asian / Asian British Bangladeshi | | | Asian / Asian British Chinese |
| Asian / Asian British Indian | | Asian / Asian British Pakistani | | | Other Asian background |
| White / Asian | | White / Black African | | | White / Black Caribbean |
| Other mixed background: | | Other ethnic group: | | | |
| Additional needs | Learning Disability | | Mental Illness | | | Dementia |
| Autism | | Acquired Brain Injury | | | Other: |
| Communication needs / preferences | English language | | Other spoken language: | | | British Sign Language |
| Pictures / symbols | | Makaton | | | Gestures / facial expressions |
| Sounds / vocalisations | | No formal means of communication | | | Other: |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Details | | | |
| Name |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  | | |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Who should we contact to arrange initial appointment: |  |
| Signature |  | | |
| Print name |  | Date referral made |  |
| Does referrer have parental responsibility for the child or young person? | | | Yes/No |

|  |  |  |  |
| --- | --- | --- | --- |
| If ‘no’ Has the person/s with parental responsibility given their consent for advocacy support?  Yes ☐ No ☐ | | | |
| Their Name |  | | |
| Mobile Number |  | Home Number |  |
| Relationship to child/ young person |  | | |

|  |  |
| --- | --- |
| Is the child or young person aware of this referral? | Yes / No |
| If ‘no’, why is the child or young person not aware of the referral? | |
| NOTE: If a referral is made without the permission of a child over the age of 13 yrs who has the capacity to consent to advocacy or the person with parental responsibility; this breach of that person’s confidentiality will be reported to the referring body’s Information Governance team in all cases. | |
| Does the child/young person lack the capacity to consent to a referral? | Yes / No |
| NOTE: where you identify that the child/young person lacks capacity to consent to the referral, you are providing the necessary consent by submitting this form. This consent will allow the service to process the client’s information, act on behalf of the client, create anonymised case studies and share anonymised case notes for advocacy qualification training purposes or commissioning reports. | |

|  |  |
| --- | --- |
| Are there any current risks we need to be aware of: | |
| Reason for Advocacy referral: | |
| Are there any upcoming meetings or deadlines we need to be aware of: | |
| A meeting between the child/young person and their advocate can be anywhere that they find comfortable or appropriate, such as in a public place like a café, at school/college, or their home. Please tell us about any preferences that the child/young person has expressed. | |
| **Referral Details:** please tick all criteria which apply | |
| **Current situation of the child or young person** | |
| Subject to a Child Protection plan |  |
| Subject to a Child in Need plan |  |
| Looked after Child |  |
| Care Leaver |  |
| 16/17 years old and homeless |  |
| A disabled child/young person receiving a social care service |  |

|  |  |
| --- | --- |
| **Social worker Name:** |  |
| **Social worker location:** |  |
| **Social worker team:** |  |
| **Social Worker email address:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| For CYP service use | | | |
| Date referral received |  | CYP assigned to case |  |
| RIS number |  | Person processing referral |  |

Email this form to: [essexadvocacy@rethink.org](mailto:essexadvocacy@rethink.org)

Send by post to: Rethink Advocacy, Saxon House, 27 Duke Street, Chelmsford, CM1 1HT

Telephone: 0300 790 0559

**General Data Protection Regulation (GDPR)** All records are kept in accordance with current GDPR legislation

For concerns or complaints regarding the referral please contact

Contract Manager:

Head of Service: Catherine Mercer: [catherine.mercer@rethink.org](mailto:catherine.mercer@rethink.org)