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| **Please note all fields must be completed or the form will be returned: this could delay an Advocate being allocated. Where Not Applicable please indicate by inserting N/A** |
| **This service is for children and young people, receiving a service from Essex Children’s Social Care.** **Eligible children and young people receiving social care services include:** * **Children in care**
* **Children assessed as in need including children and young people subject to a child protection or children in need plan**
* **Children with disabilities**
* **Care leavers**
* **Homeless 16- to 17-year-olds being assessed by children’s social care**
 |
| **Date of Referral** |
| **Child or Young Person’s Details** |
| Name |  | Client DOB |  |
| Home Address |  |
| **Address at point of referral** (if different from above). If hospital, please include ward name/number |  |
| Post code |  | Local Authority/Borough |  |
| Telephone |  | Email |  |
| Please state how the chid or young person would prefer to be contacted by the advocate or service:  |
| GP Surgery registered with |  | GP Surgery contact number |  |
| **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 |  |
| **Please provide the reason for 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: |
| **Referrer Details** |
| Name  |  |
| Job Title |  |
| Team and Department |  |
| Local Authority/Borough |  |
| Telephone |  |
| Email |  |
| Does the 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 |  |
| Contact details |  |
| Their relationship to the 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? | Yes/No |
| Does the child/young person lack the capacity to consent to a referral? | Yes/No |
| 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. |
| Please detail any risk issues the advocacy service needs to be aware of below, or confirm there are no known risks |
|  |
| **If not the referrer, please complete the details of the child or young person’s social worker below** |
| **Name** |  | **Job Title** |  |
| **Telephone No** |  | **Email** |  |
| **Social worker location/local authority** |  | **Date** |  |
| **Additional information – Please tick those that apply** |

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| **Religion or spiritual belief** |
| Buddhist |  | Jewish |  | Other Religion |  |
| Christian |  | Muslim |  | No Religious Belief |  |
| Hindu |  | Sikh |  | Do not wish to answer |  |
| **Ethnicity** |
| Asian or Asian British - Any Other Asian Background |  | Mixed - Any other mixed background |  | White - Any Other White Background |  |
| Asian or Asian British - Bangladeshi |  | Mixed - White and Asian |  | White - British |  |
| Asian or Asian British - Indian |  | Mixed - White and Black African |  | White - Gypsy or Irish Traveller |  |
| Asian or Asian British - Pakistani |  | Mixed - White and Black Caribbean |  | White - Irish |  |
| Black or Black British - African |  | Do not wish to answer |  | Not provided |  |
| Black or Black British - Caribbean |  | Other Ethnic Group - Any other ethnic group |  | Do not wish to answer |  |
| Black or Black British - Other Black Background |  | Other Ethnic Group - Arab |  |  |
| **Sexual orientation** |
| Heterosexual / Straight |  | Bisexual |  | Not Provided |  |
| Homosexual / Gay Man |  | Other |  |  |
| Lesbian / Gay Woman |  | Do not wish to answer  |  |  |
| **Additional needs** |
| Learning Disability |  | Mental Illness |  | Dementia |  |
| Autism |  | Acquired Brain Injury |  | Other |  |
| **Communication needs / preferences** |
| Preferred language (please specify) |  | English language |  | Other spoken language (please specify) |  |
| Preferred method of communication (please specify) |  | Able to read |  | British Sign Language |  |
| Pictures / symbols |  | Makaton |  | Gestures / facial expressions |  |
| Sounds / vocalisations |  | No formal means of communication |  | Other support needs |  |
| Hearing impairment |  |  |
| **Other** |

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| --- | --- | --- | --- |
| Gender |  | Identifies as same sex as at birth | Yes/No/Prefers not to answer |
| Marital status |  |

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| --- |
| Pregnant /maternity Yes/No |
| Mental health diagnosis: |
| **Please return this referral to:**essexadvocacy@rethink.orgTelephone: 0300 790 0559 |