



Swindon Advocacy Movement
 Swindon Advice and Support Centre
 Sanford House
 Sanford Street
 Swindon
 SN1 1QH
 Telephone on 01793 542575/616562
 Fax Number 01793 423124
 Email info@swindonadvocacy.org.uk

Spot Purchase Parent Advocacy Referral Form

Client Details			
Full Name:			
Date of Birth:			
Current address:	Contact telephone numbers:	Accommodation Type:	
		Home Owner	
		Living with Family	
		Social Housing Tenant/Council House	
		Private Tenant	
		Supported Housing	
		Hostel	
		Hospital	
		Parent/Family Placement	
Parent assessment unit			
G P Name:			
Address:			
Telephone Number:			
Childrens' details:	Name	Address	Date of Birth
Name of Local Authority:		Address:	
Name of Children's Social worker:		Contact address:	
		Email address:	
		Contact telephone number:	

Name of parents legal representative:		Contact address:	
		Email address:	
		Contact telephone number:	
Other professionals involved in clients life:			
What is the best way for us to contact the client?			
Has this person agreed for this referral to be made	Yes:	No:	
Is an interpreter required?	Yes:	No:	
If yes what language is spoken?			
Name of person within Children's Services who will authorise the provision of an interpreter:			
Invoicing name and address or Purchase Order Number			

Risk Assessment:
This section needs to be completed in order for us to provide a service to the client. Please indicate below anything in the client's history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home.
Any known mental health issues:
Any behaviours we need to know about:
Any known risks in lone working/visiting at home i.e. friends, family, history etc:
Any particular health needs i.e. Epilepsy, Asthma etc:
Any particular communication needs:
Any other details we need to be aware of:

In accordance with the Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client.

Signed (Client) _____ Date _____

Signed (Referrer) _____ Date _____

"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment"



Swindon Advocacy Movement
April 2016 – March 2019

Swindon Advocacy Movement
Swindon Advice and Support Centre
Sanford House
Sanford Street
Swindon
SN1 1QH
Telephone on 01793 542575/616562
Fax Number 01793 423124

EQUAL OPPORTUNITY MONITORING FORM

Swindon Advocacy Movement is committed to managing diversity and ensuring equality of opportunity for all. We will treat all cases fairly and equally in all aspects of their race, disability, gender, age, religion or belief, sexual orientation, marital status, pregnancy, maternity and sex.

In order to ensure the continued development of our Equal Opportunities and Diversity Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
I am:	Married	Single	Divorced/ Separated	Widowed	Prefer not to say		
My Gender Is:	Male	Female	Transgender		Prefer not to say		
Sexuality:	Heterosexual	Homosexual	Lesbian	Bisexual	Prefer not to say		
My Religion is:	Christian	Muslim	None		Prefer not to say		
	Sikh	Hindu	Other (please state)				
Employment Status:	Employed	Unemployed	Registered Disabled	Retired			
Age Groups	16-24	25-34	35-44	45-54	55-64	65+	Prefer not to say
I am	Pregnant	Or Maternity	Prefer not to say		Not applicable		
Post Code:							
Ethnicity:							
White British			Asian – British or Indian				
White Irish			Asian – British or Pakistani				
White Other			Asian – British or Bangladeshi				
Please specify;			Any other Asian background				
Mixed – White & Black Caribbean			Black – British or Black Caribbean				
Mixed – White & Black African			Black – British or Black African				
Mixed – White & Asian			Other Black				
Mixed – White Other			Oriental - Chinese				
Any other mixed background			Oriental – Other				
			Not Established				
Disability:							
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? Please tick							
Yes		No		Prefer not to say			
If you have answered yes to the question above, how would you best describe your disability. Please tick all that apply							
Hearing		Speech		Physical		Mental Health	
Visual		Mobility		Learning		Other	