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

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:**			
Children's' details:	**Name**	**Address**	**Date of Birth**
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?		
What reasonable adjustments have been made?		
Communication needs of client?		
Please detail what assessments have taken place for the parent, e.g. Capacity, Cognitive, Care Needs assessment, PAMS:		

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:

Here at SAM we take your privacy seriously and will only use your personal information to provide you with independent advocacy in accordance with the General Data Protection Regulations.
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 your express consent. Please see our Privacy Notice on request or on our website.

Signed (Client) _____ Date _____

Signed (Referrer) _____ Date _____

Senior Manager _____ 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"

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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						
Are you Married or in a Civil Partnership	**Yes**	**No**	**Prefer not to say**			
Gender:	**Male**	**Female**	**Transgender**	**Prefer not to say**		
Sexual Orientation:	**Heterosexual**	**Gay man**	**Gay woman/ Lesbian**	**Bisexual**	**Prefer not to say**	
Religion:	**Christian**	**Muslim**	**None**	**Buddist**	**Jewish**	
	Sikh	**Hindu**	**Other (please state)**	**Prefer not to say**		
Employment Status:	**Employed**	**Unemployed**	**Registered Disabled**	**Retired**	**Student**	**Prefer not to say**
Age Groups	**Under 16**	**16-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**Prefer not to say**
Post Code:	**Prefer not to say**							

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**	
Prefer not to say		**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**	