LEAP Advocacy Service Referral Form

Please email this form to enquiries@leapadvocacy.org.uk

[ ] Self referral (Please fill out client information)

 [ ] Professional referral (Please fill out details below)

Date complete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Information**

|  |  |
| --- | --- |
| Full Name  |  |
| Preferred Name (if different from above) |  |
| Gender |  |
| Preferred pronoun(s) (ie. She, He, They) |  |
| Date of birth  |  |
| Address |  |
| Postcode  |  |
| Phone Number  |  |
| Email address |  |
| Preferred contact method | [ ]  Phone [ ]  Email [ ]  Post [ ]  Text [ ] Other |
| Do you have a preferred time of day for contact?  |  |
| Communication Needs? | [ ]  Interpreter Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Easy Read [ ]  Large Print [ ] Makaton or Pictorial [ ] Braille [ ] British Sign Language [ ]  Minicom [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ethnicity |  |
| Nationality |  |
| Religion |  |
| We aim to support everyone respectfully. If you would prefer to speak with someone who understands your culture or background, or if you have any other support or specific adaptation needs, please let us know |  |

**Referrer Information**

|  |  |
| --- | --- |
| Date of Referral |  |
| Referrer Name  |  |
| Organisation  |  |
| Contact Number  |  |
| Email Address  |  |

## Consent

Has the client given informed consent to this referral? ☐ Yes ☐ No

If no, please outline why referral is made without consent:

## Reason for Referral

Brief description of the advocacy issue:

Issue Type (tick all that apply):

[ ]  Mental Health [ ]  Social Care [ ]  Carers [ ]  Access to services [ ]  Financial

[ ]  Disability [ ]  Physical Health [ ]  Housing [ ]  Safeguarding [ ]  Other (please provide details above)

**For Professional Referrals:**

## Risk and Safeguarding

Are there any risk or Safeguarding concerns that we need to be aware of

## Office Use Only

|  |  |
| --- | --- |
| Date received  |  |
| Triaged by  |  |
| LEAP Referral accepted?  | [ ]  Yes [ ]  No  |
| LEAP Partner referrals | [ ]  ECC [ ]  One to One [ ]  Precious [ ] CAB [ ]  MAB  |
| Statutory Advocacy needs?  | [ ]  CAA [ ] IMCA [ ]  IMHA [ ] IHCA  |
| Other external referrals  | [ ]  Carers support [ ] DANE [ ]  UCAN [ ] Hospital Discharge |
| Consent for onward referrals?  | [ ]  Yes [ ]  No |
| Notes |  |