LEAP Advocacy Service Referral Form

Please email this form to [enquiries@leapadvocacy.org.uk](mailto: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 |  |