ADVOCACY REFERRAL FORM - CONFIDENTIAL

|  |  |  |  |
| --- | --- | --- | --- |
| Please tick appropriate Advocacy | | | |
| Generic Advocacy 🞏 | Independent Mental Health Advocacy 🞏  (Please include detail of section under Mental Health Act 1983 (amended 2007) | Independent Mental Capacity Advocacy 🞏  (Please attach checklist for assessment of Best Interests) | Young Person and Children Advocacy 🞏 |

**Client Details**

Name …………………………………………………………………………………… Title ……............

Address ……………………………….…………………………….…………………………...………….…

…………………………………………………………………………... Post Code ………………………

Mobile/SMS ………………………………….. Email ………………………………………………….……

Communication Method - Sign Language  Deaf/Blind Manual  Lip Reader  Speech

Date of Birth …….…/…....…/………… Gender Male / Female ………………………………..…

Do you have the internet at home? Yes/No Use what for Video Calls: **WhatsApp**? Yes/No

**FaceTime**? Yes/No **Zoom** Yes/No or **something else** ………………………….……

**Patient has given consent for SignHealth Advocacy Service to stored referral and information on SignHealth’s secure confidential system in accordance with the Data Protection Act 2018. Yes/No**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnicity** | Please circle ethnicity below: | | |
| White | British | Irish | Other White Background |
| Mixed | White & Black Caribbean | White & Asian | Any other mixed background |
| White & Black African |
| Asian or Asian British | Indian | Pakistani | Bangladeshi |
| Any other Asian background | | |
| Black or Black British | Caribbean | African | Any other Black background |
| Other ethnic groups | Chinese | Any other ethnic group | |
| Not stated | | | |

# Referral Issue

Please Give Details ……………………………………………………………………………………..…

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Use separate sheet for additional information if required

**Current Medication if appropriate**  …..…………………………………………………………………...

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Continue on separate sheet if required

**Contacts**

|  |  |
| --- | --- |
| Funding Details with billing address | Address & Contact Number: |
| Name of Family Contact (if appropriate | Address & Contact Number: |
| Name of GP/Health Worker: | Address & Contact Number: |
| Other Services/Agencies Involved: | Address & Contact Number: |

Please Return to:

SignHealth Advocacy Service CAN Mezzanine Ltd 7-14 Great Dover Street London SE1 4YR

Email to [advocacy@signhealth.org.uk](mailto:advocacy@signhealth.org.uk)

Contact details:

07984439473 SMS only

07966 976747 Voice