|  |  |
| --- | --- |
| Advocacy for adults (16 +) and older adults (65+) in South Lanarkshire | |
| **Return via email to south.referrals**[**@equalsay.org**](file:///C:\Users\brenda\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\N8UHQUHM\brenda@equalsay.org) | |
| ***Date*** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Advocacy Partner Details** | | | | | | | | | | | | | | | | | | | | |
| ***Name*** |  | | | | | | | ***Date of birth*** | | | |  | | | | | | | | |
| ***Gender*** | Male |  | | Female | |  | | Other | | | |  | | Prefer not to say | | | | | |  |
| ***Ethnicity*** | White |  | | Black | |  | | Asian | | |  | Mixed Background | | | | |  | Not  known | |  |
| Other |  | |  | | | | | | | | | | | | | | | | |
| ***Client Group*** | Learning Disability | |  | | Mental Health | | | |  | Physical Disability | | |  | | Long Term Condition | | | |  | |
| Addiction | |  | | Acquired Brain Injury | | | |  | Dementia | | |  | | | Older Person | | |  | |
| Other (please give details) | | | | | |  |  | | | | | | | | | | | | |
| ***Telephone 1*** |  | | | | | | | ***Telephone 2*** | | | |  | | | | | | | | |
| ***Email*** |  | | | | | | | | | | | | | | | | | | | |
| ***Any communication needs we should consider to communicate effectively?*** | | | | | | | |  | | | | | | | | | | | | |
| ***Address*** | | | | | | | | ***Current location*** *(if not at home)* | | | | | | | | | | | | |
| ***Home Address 1*** |  | | | | | | |  | | | | | | | | | | | | |
| ***Home Address 2*** |  | | | | | | |  | | | | | | | | | | | | |
| ***Home Address 3*** |  | | | | | | |  | | | | | | | | | | | | |
| ***Postcode*** |  | | | | | | | ***Postcode*** | | | |  | | | | | | | | |

|  |
| --- |
| ***Is there anything we need to know to keep everyone safe?***  Please include any knowledge you have of the partner for us to include in our risk assessments for visits |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | | | | | | | | | | |
| ***Referred by*** | Social Work |  | Self |  | Family |  | Equal Say | |  | Service Provider | | |  | MHO | |  |
| Health |  | | Addictions | |  | Other | |  |  | | | | | | |
| ***Name*** |  | | | | | | | | | | | | | | | |
| ***Relationship*** |  | | | | | ***Telephone*** | | |  | | | | | | | |
| ***Email*** |  | | | | | | | | | | | | | | | |
| ***Confidential referral?*** *(i.e. Keep my identity secret)* | | | | | | | | YES | | |  | NO | | |  | |
| ***Has this referral been discussed with the advocacy partner?*** | | | | | | | | YES | | |  | NO | | |  | |

|  |
| --- |
| **Relevant Details:** background, presenting issues, agencies working with the person, communication style etc. |
|  |
| **Why are you making this referral? What is your expectation of advocacy?** |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Legislation*** | AWI | |  | ASP | |  | | | CP | |  | | MHA |  | None |  |
| ***Next meeting*** |  | | | | | | | | | | | | | | | |
| ***Date*** |  | | | | | | | ***Time*** | |  | | | | | | |
| ***Location*** |  | | | | | | | | | | | | | | | |
| ***Contact*** |  | | | | | | | | | | | | | | | |
| ***Guardianship or Power of Attorney?*** | | Welfare  Guardian | | |  | | Power of Attorney | | | |  | Financial Guardian | | |  | |
| ***Name*** | |  | | | | | | ***Telephone*** | | |  | | | | | |
| ***Relationship*** | |  | | | | | | ***Email*** | | |  | | | | | |

|  |  |
| --- | --- |
| **Other Agencies/ Contacts** | |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |