Our **Independent Advocacy** services exists to make sure people with **learning disabilities and/or autism spectrum conditions** have a voice in situations they may find hard to deal with by themselves.

Please use this form to request a service for initial issues. If, after these issues have been tackled, the person needs additional advocacy support, please use a **new** referral form to request more advocacy.

Self-referrals: We **highly** recommend phoning us so that we can help you complete this form and provide us with the right information.

**Is this referral being made to meet the statutory requirements of the Social Services and Well-being (Wales) Act 2014 to provide advocacy support?**

**Yes**  **No**  **Unsure**

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| **Section 1.** ServiceRecipient Details | | |
| 1. **Full Name:** | | |
| 1. **Date of Birth:** | | **Age:** |
| 1. **Gender:**   Male  Female  Prefer not to say  Other (Please Specify): | | |
| 1. **Client Group** (Tick all that apply)**:**   Learning DisabilityAutism  Other(Please specify): | | |
| 1. **Contact Details:** | | |
| Street Address:  County:  Postcode: | Email:        Phone: | |

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| **Section 2.** Referrer Details |
| 1. **Who is making the referral?** |
| Third-party Self (Skip to **v.**) |
| 1. **Full Name:** |
| 1. **Contact Details:**   Email Address:    Phone Number: |
| 1. **Referrer’s relationship to the individual being referred:**   (Please click the text below to select from the drop-down menu)   |  | | --- | |  |   If Other, please specify:  **If a professional, could you provide your job title:**  **Line manager’s full name:** |
| 1. **How did you find out about People First Bridgend’s Independent Advocacy Service?**   Bridgend Voice and Choice Advocacy Hub  Word of mouth  Previous Referrer/Service Recipient  Internet (Please specify where):  Signposted (Please specify who by):  Other (Please specify): |

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| **Section 3.** Referral Details (Part 1) |
| 1. **Does the Service Recipient have a Social Worker?**   Yes  No  Unsure   1. **Are Social Services involved in the advocacy issue?**   Yes  No  Unsure |
| 1. **How would you describe the advocacy issues present?**   (Tick all that apply)  Assessment / care and support planning / reviews  Accessing information, advice and assistance  Accommodation issues (including care homes)  Change of service type / preparing to return to the community from hospital  Concern / dissatisfaction / complaint  Safeguarding  Other (Please specify): |

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| **Section 3.** Referral Details (Part 2) |
| 1. **Can you tell us about the person’s situation and how you think we could help?** |
| **Section 3.** Referral Details (Part 3) |
| 1. **What is the best way for us to communicate with the Service Recipient?** |
| 1. **Are there any important deadlines or meeting dates that we should know about in relation to this referral?**  |  |  |  |  | | --- | --- | --- | --- | | **Date** | **Time** | **Location** | **Description** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Any further information relating to the meetings listed:** |
| 1. **Are there any other professionals supporting the Service Recipient in relation to this referral? If so, could you provide their names, roles and contact details?**  |  |  |  |  | | --- | --- | --- | --- | | **Full Name** | **Role** | **Phone Number** | **Email Address** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Any further information relating to those listed above:** |

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| **Section 4.** Supporting Information |
| 1. **Does the Service Recipient have any health issues we should know about? (e.g. epilepsy)** |
| 1. **Does the Service Recipient have any risks associated with them or their situation that we should know about? (e.g. violent partner, dangerous dog)** |
| 1. **Please add any additional information you feel we should know that would help us to support the Service Recipient:** |
| **Section 5. Consent to Service and Data Protection** |
| I, the third-party or self-referrer, confirm that I have obtained consent from the Service Recipient to make this referral to People First Bridgend’s Independent Advocacy Service.  **Yes**  **No**  Consent to receive a service can be withdrawn at any time and the person will inform People First Bridgend if they change their mind.  If the person does not have capacity on this occasion, could you confirm that the referral has been made as the result of a best interest decision:  **Yes**  **No**  **General Data Protection Regulation 2016 and Data Protection UK Act 2018**  People First Bridgend processes the personal information contained in this referral under the Contract lawful basis of the GDPR(EU) 2016 and DPA(UK) 2018.  We use this information only to provide an adequate service and for monitoring reports to our funders, Bridgend County Borough Council (monitoring information will be anonymised). We store all information securely behind physical and digital locked storage.  If you would like a full copy of our privacy notice, have queries about our Data Protection Policy or would like to request copies of your data, please contact us at [admin@peoplefirstbridgend.co.uk](mailto:admin@peoplefirstbridgend.co.uk), or write to us using the address at the top of this form. |
| Please can the person who has filled in this form sign and date here:  (We recommend printing/scanning to PDF first, then adding a physical or digital signature.)  **Signature:** **Date:** |

Please return the completed form, **password protected** by email to [advocacy@peoplefirstbridgend.co.uk](mailto:advocacy@peoplefirstbridgend.co.uk)

Please send a **separate email with the password**.

Or post the completed form to the address listed at the top of the form.