**Date of Referral:** …………………………………………………………………………………………………………………

Has consent for this referral to be made been given: Verbal/written/other Yes  No 

If ‘no’ please indicate why? ………………………………………………………………………………………………………

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| **Person Referred:** …………………………………………  Name: ………………………………………………………  Address: ……………………………………………………  ………………………………………………………………  ………………………………………………………………  Tel: (Home) …………………………………………………  (Mobile) …………………………………………………  DOB: ………………………… Age: ……………………… | **Referred by:** ………………………………………………  Name: ………………………………………………………  Relationship to person being referred: …………………  ………………………………………………………………  Address: ……………………………………………………  ………………………………………………………………  Tel: …………………………………………………………  Email: ……………………………………………………… |
| **Please outline any support currently in place:** Does the person live alone? Yes  No   Please provide contact names and details for key people (e.g. family, social worker, support worker/ key worker GP Other) ………………………………………………………………………………………………………………………… | |
| **Name:** ………………………………………………………  Relationship: …………………………………………………  ………………………………………………………………  Tel (if different): …………………………………………… | **Name:** ………………………………………………………  Relationship: …………………………………………………  ………………………………………………………………  Tel (if different): …………………………………………… |
| **Reason for Referral** (Are there any critical dates relating to this issue?)  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………… | |

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| **Does this person consider themselves to have a learning disability?** ……………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  **Does the person have any communication/ access requirements?** (What is the best way to contact this person?)  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  **Risk Assessment/Any lone Worker Issues?**  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………… |
| **Is there anyone else who can advocate for this person**? Yes  No If yes, please give details  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  **Have you referred this person to any other advocacy services?** Yes  No If yes, please give details  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  **Any additional Information**  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………  ……………………………………………………………………………………………………………………………………… |

Referrals under the **Care Act** are accepted on the Brighton and Hove Advocacy Partnership (BHAP) referral form via the Community Learning Disability Team and Adult Social Care.

**Please return this form to:** jeanettegoodman@bhspeakout.org.uk

Tel. 01273 421921

Date this referral received: ……………………………… By Whom: ………………………………………………………

Date inputted to database: ……………………………… By Whom: ………………………………………………………