**Advocating Together (Dundee)**
13 Ryehill Lane
Dundee, DD1 4DD
01382 666601
enquiries@advocating-together.org.uk

# Referral Form

Any information will be treated in the strictest confidence

**Type of Advocacy required, please tick:**

☐ One to one advocacy.
An advocate supports an individual to speak up about issues affecting them. An advocate can also speak up for a person if they cannot do this for themselves.

☐ Self-advocacy.
Supports individuals within a group to build confidence and find their voice, so they can speak up for themselves.

☐ Collective Advocacy
Taking part in focus groups and feeding back your views on a variety of topics.

**Referral For**

| Name: |
|---|
| Home Address: |
| Current Address: |

Advocating Together is a Scottish Charitable Incorporated Organisation (SCIO) – Charity No: SC 026064

The information provided will be processed in accordance with Data Protection Principles as set out in the Data Protection Act (1998), and the General Data Protection Regulations (2018). Data will be processed only in the best interests of Advocating Together (SCIO) Dundee, staff, members, trustees and volunteers. Information provided will not be used for any other purpose.

| Tel No: |
| --- |
| Email: |
| D.O.B:<br><br>*(please note we support adults over the age of 21 only)* |
| Ethnicity: |
| Gender: |

**Date referral made:**

Has this referral been discussed and agreed with this person?
**Yes** ☐ **No** ☐

If no, please provide a reason

| |
| --- |
| |

Please indicate whether the person seeking advocacy support:
(Please highlight all that apply)

☐ Has a learning disability
☐ Has an autistic spectrum disorder

Does this person also have complex communication needs?
☐ No
☐ Yes, please describe below:

| |
| --- |
| |

**Referred by:** **Self** ☐ **Other** ☐

| Name: |
|---|
| Designation: |
| Organisation: |
| Address: |
| Telephone Number: |
| E-Mail : |

**<u>For One to one advocacy</u>**
**Others involved.**

Is there any contact with the following? Please give details (names & addresses)

| **SOCIAL WORKER/CARE MANAGER** Yes ☐ No ☐ |
|---|
| Name: |
| Address: |
| Tel Number: |
| Email: |
| Can we contact the Social Worker/Care Manager for more information?<br>**Yes** ☐ **No** ☐ |



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| **Other Relevant Contacts e.g. GP, CPN, Family etc.**<br>**Yes ☐ No ☐** |
|---|

| **Name** | **Address** | **Phone number** | **Relationship** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| Can we contact any of these for more information? **Yes ☐No ☐** |
|---|
| If so, who? |

| Is the person deemed to have capacity? | **Yes ☐** | **No ☐** | **Unknown ☐** |
|---|---|---|---|

| **Do they have any of the following?** | | | |
|---|---|---|---|
| Welfare Guardian | **Yes ☐** | **No ☐** | **Unknown ☐** |
| Financial Guardian | **Yes ☐** | **No ☐** | **Unknown ☐** |
| Power of Attorney | **Yes ☐** | **No ☐** | **Unknown ☐** |
| Appointeeship | **Yes ☐** | **No ☐** | **Unknown ☐** |
| If any of the above apply, please add the contact details in the Other Relevant Contacts box above. | | | |

## What advocacy support do they need?

**Dates, times, location and reason for any upcoming meetings**

| Date of meeting | Time of meeting | Location of meeting | Reason for meeting |
|---|---|---|---|
| | | | |
| | | | |

## For all referrals

**Additional Information (general/medical):** *to include other known medical conditions such as, sensory impairment i.e. deafness, blindness, acquired brain injury, epilepsy or a long-term condition, such as MS, Parkinson's etc. (Please continue on a separate sheet if necessary)*



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Please indicate if you know of any reason why the person being referred should not be visited at home or interviewed alone

| |
|---|
| |

| Pet owner | **Yes** ☐<br><br>Dog/cat how many? | **No** ☐ |
|---|---|---|

Thank you for completing this referral form

Signature of referrer: ……… …………………………………………….

Date: ……………………………………………………

**These details above will be kept on file and we would be grateful if you can inform us of any changes.**

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