Brighton & Hove Speak Out

Advocacy Referral Form

Date of Referral:

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

If 'no' please indicate why?

Person Referred:

Name:

Address:

Home Tel:

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 (eg 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?):

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: referrals@bhspeakout.org.uk
Tel. 01273 421921

Date this referral received: By Whom:

Date inputted to database: By Whom: