

## SPOT PURCHASE ADVOCACY REFERRAL FORM

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| ***For Information and advice on how to complete this form please phone the Devon Advocacy Consortium on 01392 822377***  ***Failure to complete all relevant parts of this form will result in delayed allocation of this referral.***  ***The referral form should be emailed to*** [***devonadvocacy@livingoptions.org***](mailto:devonadvocacy@livingoptions.org) |

### DETAILS OF THE PERSON BEING REFERRED

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | D.O.B |  |
| Permanent Address |  | Age |  |
| Gender |  |
| Postcode |  | Tel |  |
| Current address |  | Tel |  |
| Postcode |  | Email |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client currently living in | Own home |  | Care home |  | Hospital |  | Supported living |  | Prison |  | Uncertain |  | Other (specify) |  |

**WHY DOES THE PERSON NEED AN INDEPENDENT ADVOCATE?**

|  |  |
| --- | --- |
| Brief outline of the issue |  |
| Dates & times of any planned meetings |  |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Disability | | | | | | | | | Acquired Brain Injury |  | Autistic Spectrum Condition |  | Cognitive impairment |  | Dementia |  | | Learning Disability |  | Mental Health problems |  | Serious Physical Illness |  | Combination |  | | Unconsciousness |  | Other  (please state) |  | | | | | | |
|  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the person being referred pose a risk to themselves or others? Yes | |  | No |  |
| Details: |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| What is the primary communication method? (tick only one box – the most appropriate) | | | | | |
| English |  | Other spoken language |  | Gestures/vocalizations/facial expressions |  |
| Sign language (e.g. BSL) |  | Words/Pictures/Makaton |  | No obvious means of communication |  |
| Other (please state) |  | | | | |

**REFERRER**

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name |  | Name of Org, if applicable |  |
| Relationship to client |  | Your Tel |  |
| Your Address |  | Your Mobile |  |
| Your Email |  |
| Date of referral |  | | |

**INVOICING DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name of Org |  |
| Address |  | Tel |  |
| Email |  | Purchase order number |  |

**CLIENT MONITORING INFORMATION**

**We are required to request the following data to ensure that our service is fair and treats our users equally. This information is separate to your referral for advocacy and has no impact on the service that we will provide.**

**The following questions are optional.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the gender the client identifies with the same as their sex registered at birth? | Yes |  | No |  |

**Ethnic Origin:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White:** |  | **Mixed:** |  | **Asian or Asian British:** |  | **Black or Black British:** |  | **Other** |  |
| British |  | White & Black Caribbean |  | Indian |  | Black Caribbean |  | Other Ethnic Group (please specify) |  |
| Irish |  | White & Black African |  | Pakistani |  | Black African |  | Not Established |  |
| Other White (please specify) |  | White & Asian |  | Bangladeshi |  | Other Black (please specify) |  |  |  |
|  |  | Other Mixed  (please specify) |  | Chinese |  |  |  |  |  |
|  |  |  |  | Other Asian (please specify) |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the client married or in a civil partnership? | Yes |  | No |  |

|  |  |
| --- | --- |
| How does the client describe their sexual orientation? |  |

|  |  |
| --- | --- |
| What religion is the client? |  |

The Devon Advocacy Consortium is a partnership made up of 4 specialist advocacy providers: Living Options Devon (lead), Rethink Advocacy, Vocal Advocacy and Young Devon.

Devon Advocacy Consortium

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