**Independent Advocacy – Confidential Referral Form**

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| **About the Person making thIS Referral** | | | |
| Your Name |  | Referral Date |  |
| Your relationship to child or young person |  | CYP’s Social Worker Name |  |
| Your Telephone no/s |  | SW Telephone no/s |  |
| Your email address |  | SW Email Address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILD or YOUNG PERSON DETAILS** | | | |
| FIRST NAME/S |  | SURNAME |  |
| Also known as |  | Agreed to this Service? | Y/N |
| Owns a phone? | Y/N | Their contact number |  |
| Local Authority |  | Who has Parental Rights |  |
| AGE / DATE OF BIRTH |  | BIRTH COUNTRY |  |
| Nationality |  | Ethnicity |  |
| Religion |  | Disability (registered?) |  |
| Sex at Birth |  | Sexual Orientation |  |
| Gender Identity |  | Preferred Pronouns |  |

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| **CYP / CARER / ACCOMMODATION INFORMATION** | | | |
| FULL POSTAL ADDRESS |  | | |
| Carer/s Name/s |  | Role/s |  |
| Tel. Nos. Landline |  | Mobile |  |
| Aware of this referral? | Y/N | Email/s |  |

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| **OTHER PROFESSIONALS / AGENCIES INVOLVED** (If details not above) | | | | |
| **Roles** | **Name** | **Organisation** | **Tel. Number/s** | **Email address** |
| SW Team Manager |  |  |  |  |
| IRO |  |  |  |  |
| Keyworker |  |  |  |  |
| PA, Leaving Care |  |  |  |  |
| Adult SW, Leaving Care |  |  |  |  |
| Others |  |  |  |  |

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| **About the Child / Young Person** (continued) | |
| **Details of any other relevant legislation in place relating to this CYP?** | |
|  | |
| **Any information that may help with communication, e.g., additional needs; preferred time and place to meet; preferred language; is non-verbal?** | |
|  | |
| **Are there any current known risks which may affect young person, staff, or volunteer safety? Any triggers or control measures needed. Please summarise here** | |
| Violence |  |
| Self-harm |  |
| Substance misuse |  |
| Inappropriate behaviour |  |
| Gang involvement |  |
| Allegations |  |
| Absconding |  |
| Areas/people to avoid |  |
| Any other known risks |  |
| **Please provide a brief history and the reason for the referral; please include any relevant meeting dates** | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

Please return completed form by secure/encrypted email to:

**DCRS.Advocacy@cgl.org.uk**

Alternatively you can post a printed copy, marked as Private & Confidential, to the office detailed below. Please ensure it is sent via a special delivery signed-for service.

**Derby Children’s Rights Service Advocacy**

Change Grow Live

Rm 7, Halliday House

2 Wilson Street

Derby

DE1 1PG

For support or advice in completing this referral form please contact:

[**DCRS.Advocacy@cgl.org.uk**](mailto:DCRS.Advocacy@cgl.org.uk) (preferred)

or telephone 01332 294534