**Disability Outreach Advocacy**

Referral Form

**Please note:** **Only proceed with this form if the young person you are referring meets the following criteria:**

* The child or young person **has a learning disability and/or autism**
* The young person either already receives support from children’s or adults social care, or has an education health and care plan (EHCP), or would benefit from SEND or social care support.
* The child/young person is **younger than 25 years old.**
* The young person is **not** a looked after child/in care or a care leaver, and **not** to your knowledge already supported by another advocacy service for children or adults.
* If the child or young person is able to understand this referral, you have gained their consent and they have agreed for us to contact them. (If the young person lacks capacity to understand the contents of the referral, you may proceed without their consent)
* If the child is under 18 years old and cannot provide consent, their parent or legal guardian has consented to this referral on their behalf.

If you are unsure about any the above please contact the Coram Voice Advocacy Helpline to discuss the referral, before completing this form: **0808 800 5792**

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| CHILD/YOUNG PERSON | | |
| First name of child/young person: | | **Surname of child/young person** |
| Has the child/young person consented to this referral?  (NB: We cannot progress referrals if a young person who is able to instruct an advocate has not consented to this referral  Yes  No  Not applicable (young person lacks capacity to consent) | | |
| Please give details of young person’s disabilities/additional needs: | | |
| Does the child/young Person have any communication needs? Please provide details:  (E.g. uses symbols, Makaton, BSL, electronic communication aid, non- verbal communication etc.) | | |
| Does the young person have an Education Health and Care Plan (EHCP)  Yes  No  Not known | | |
| Child/Young Person Address: | | |
| Child/Young person phone numbers: | | |
| Responsible Local Authority: | | |
| Date of birth: Click here to enter a date. | | |
| Age: | | |
| Gender: | | |
| Ethnicity: Click here to enter text. | | |
| Preferred language: | | |
| PARENT/LEGAL GUARDIAN | | |
| Name(s) of parent/ carer(s): | **Phone no(s):** | |
| **Email address (es):** Click here to enter text. | |
| Address: | | |

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| ADVOCACY ISSUES |
| Our advocates can support young people to make their wishes, feelings and rights known to Children’s or Adults Social Care and/or Local Authority SEND teams.  Please explain below why you are referring this young person to Coram Voice, including their specific advocacy issues.  (some examples of possible advocacy issues could include things like: transition planning, accommodation, care packages, access to education or activities, the need for specialist equipment or health support, or any other issue important to this young person) |
| Upcoming key dates / meetings: |

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| SOCIAL WORKER (IF KNOWN) |
| Name: |
| Position: |
| Social worker’s telephone numbers: |
| Social worker’s email address: |
| Name of Social worker’s team: |
| Address of Social Services Team: |
| Name and contact details of Social Care Team Manager: |
| Team Manager’s telephone numbers: |
| Team Manager’s email address: |
| Name of team: |
| Address of Social Services Team: |
| If applicable, name of any other relevant professional, such as SEND case officer: |
| Professional’s telephone numbers: |
| Professionals’ email address: |
| Name of team: |
| Address of Team: |

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| REFERRER’S DETAILS |
| Name: |
| Relationship to child or young person: |
| Agency (if professional): |
| Phone numbers: |
| Email address: |
| Address: |
| Date of referral: |

**Please note, we are a transparent, young person led service and if the young person has capacity to understand the contents of this form, we will discuss all information on this form with them.**

**Please email this form to help@coramvoice.org.uk**