**Ref no**

**Advocacy Service: Referral form**

**Self-referral o**

**Referral by family member/friend o**

**Referral by health/social care organisation o**

**Referral by other service provider o**

**The information provided in this form will be stored by Age Cymru on a secure system. By completing this form you are consenting for us to hold this information for case work only.**

|  |  |
| --- | --- |
| **Has permission been given for this referral?** | **Yes o****No o – if the answer is no permission must be gained before the referral can progress** |
| **How was permission given?** | **In person o****Via the referrer if not a self referral o****Verbally o** **In writing o**  |
| **What date was permission given?** |  |
| **Any other note in respect of permission** |  |

**Referrer’s details (if not self-referral)**

|  |  |
| --- | --- |
| **Name:** | **In what capacity the referrer knows the person:** |
| **Agency (if relevant) and address:** |
| **Postcode:** | **Tel no:**  |
| **E-mail:**  | **Date of referral:** |

|  |
| --- |
| **Outline of the Advocacy issue:**  |

**Personal details of the person being referred**

|  |  |
| --- | --- |
| **Full name:**  | **Mr/Mrs/Miss/Ms/Other** |
| **Known as:**  | **o Male o Female** |
| **Date of birth:** | **Age:** | **Carer: Yes No** |
| **Address (Permanent/Temporary):**  |
| **Postcode:** | **Tel no:** |
| **Mobile:**  |
| **E-mail :** |
| **Cultural/ethnic origin (ask the person/family):**  |
| **Religion:** |
| **First language:** |
| **Specialist communication needs and preferred method of communication:** |
| **Marital Status:** **Single o Married o Civil partnership o Widowed o Divorced o Separated o** |
| **Does the person live alone? Yes o No o** |
| **Other people in household:** |
| **What type of accommodation (own home, sheltered housing etc):** |
| **Has the person or the person’s spouse or partner ever served in the armed forces for longer than 24 hours, including national service? Yes o No o** |

**GP details**

|  |  |
| --- | --- |
| **Name:** | **Tel no:** |
| **Address:**  |

**Details of any health issues (e.g. other relevant medical conditions or mobility problems)**

|  |
| --- |
|  |

**Other agencies involved and contact details if available**

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| --- |
|  |

**Please return to** **advocacy@agecymru.org.uk**

|  |
| --- |
| **Internal Use only** |
| **Date referral received:**  |
| **Allocated to: (Advocate)**  |
| **Action:**  |
| **Date:** |

|  |  |
| --- | --- |
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