

 **Advocacy and Independent Visitor Service - Dorset**

**Electronic Referral Form**

**ALL FIELDS OF THIS FORM MUST BE COMPLETED IN FULL ELECTRONICALLY**

**Date:**

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| **What Service Would you like?** | **Please tick only one** |
| **Advocacy**  | [ ]  |
| **Independent Visitor Service** | [ ]  |

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| **Young Person’s Details** |
| Name of Child/Young Person:        | Address:       |
| Alternative surname:        | Town:       |
| Preferred first name:       | County:       |
| Date of Birth:       | Age:       | Post Code:       |
| Gender:       | Telephone Number:       |
| Ethnic Origin:       | Religion:       |
| Mosaic number:       | First Language(Please specify)       |
| Does child live out of County: Yes [ ]  No [ ] If yes, are they over 20 miles away? Yes [ ]  No [ ]  |
| Please tick all that apply: Category: Child In Need [ ]  Child Protection [ ]  Complaint [ ]  IMCA (Mental Health Act) [ ]   Leaving Care [ ]  Looked After [ ]  SEND transition [ ]   |
| Does the child/young person have any of the following? Learning Disability [ ]  Physical Disability [ ]  ASD [ ]  Emotional Disturbance [ ]  Speech/language [ ] Visual Impairment [ ]  Hearing Impairment [ ]  Intellectual Disability [ ]  Multiple Disabilities [ ]  Please specify      Other [ ]  Please specify       |
| Current placement type/living arrangements:      Parent/carer’s Name:       |
| School (We would normally try to see children in school):       |
| Are there any health & safety, risk or safeguarding issues our service should be aware of to keep the young person and worker safe? (e.g. drugs, alcohol, DV, animals in home)Yes [ ]  No [ ] Please specify      **If risk is significant the referrer is responsible for sharing a risk assessment with our service** |
| Does the young person agree to be contacted & seen by an advocate/IV? Yes[ ]  No[ ]  **Please note we can only take referrals where the young person agrees.** |
| Please specify who should be contacted regarding appointments with the child/YP (include contact details)       |
| Has this person given consent for the child/YP to be contacted and seen eg: in school?       Yes[ ]  No[ ]   |

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| **Reason for Referral and Case Summary***If you have any specific questions you want us to ask the young person please include in this section.* ***Please do not include any information that the young person is not aware of as we share this with them:***       |

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| Do you have any additional information that we need to be aware of? Yes [ ]  No [ ] (If Yes, we will contact you when processing the referral.) |

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| Are there any planned meetings/reviews you would like us to be involved in? Yes [ ]  No [ ]  |
| Type of Meeting:       |
| Meeting Date:       | Time:       | Venue:       |
| IRO/Chair of Meeting:       | IRO/Chair Email:       |

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| **Other Key Agencies Involved (*including Social Worker, IRO/ICRM, school etc)*** |
| Contact Name: | Role: | Agency/Team: | Contact Number: |
|       |       |       |       |
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| **Referrer’s Details**  |
| Contact Name  | Role | Email Address | Contact Number  |
|       |       |       |       |
| Team (specific):       |
| Referrer’s line manager and contact details |       |

**Please email this referral to:** **bdpadvocacy@actionforchildren.org.uk**