

**Advocacy and Independent Visitor Service - Dorset**

**Electronic Referral Form**

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

**Date:**

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

|  |  |  |
| --- | --- | --- |
| **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 | | |

|  |
| --- |
| **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:*** |

|  |
| --- |
| 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.) |

|  |  |  |
| --- | --- | --- |
| 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: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Key Agencies Involved (*including Social Worker, IRO/ICRM, school etc)*** | | | |
| Contact Name: | Role: | Agency/Team: | Contact Number: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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**](mailto:bdpadvocacy@actionforchildren.org.uk)