# Parental Child Protection Pathfinder advocacy referral form – Professional

#### *Text field boxes will expand as you type.*

#### *All data supplied to us in this form will be processed in accordance with our* [*Privacy Notice*](https://www.voiceability.org/privacy-policy/)*.*

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| --- | --- | --- | --- |
| Summary of Referral | | | |
| **Please provide details of the Advocacy support required for this client:** | | | |
| **Please provide the name of the assigned social worker.** | |  | |
| **Please provide the team name of the assigned social worker.** | |  | |
| **Please provide the date the S47 was issued?** | |  | |
| **Please provide the date the client was given the PCP Leaflet?** | |  | |
| **Details of the person you are referring** | | | |
| **First Name:** | **Last Name:** | | **DOB:** |
| **Current location** (Hospital, ward/care home and contact details): | | **Home address if different:** | |
| **Phone number:** | | **Email:** | |
| **Your client reference number,** (Mosaic, Care Direct, NHS, Prison No). | | | |
| **Name of the Child / Children relevant to this referral:** | | | |

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| **What conditions or disabilities does the parent / carer you’re referring have?** *(Please select all that apply)* | | | | | | |
| Learning disability |  | | Sensory impairment | |  | |
| Acquired brain injury |  | | Long term health condition | |  | |
| Autistic spectrum diagnosis |  | | Substance misuse/addiction | |  | |
| Dementia |  | | Physical disability | |  | |
| Neurological conditions |  | | None | |  | |
| Stroke |  | | Other *(please specify)*  Further details | | | |
| Mental health condition |  | |
| **Does the person have any access needs, for example communication or physical needs?** *(Please select all that apply)* | | | | | | |
| They need an interpreter | |  | They have physical access needs | | |  |
| They use Makaton | |  | They do not use the telephone | | |  |
| They use British Sign Language (BSL) | |  | They prefer information written down | | |  |
| They use assistive communication (e.g. Symbol book, Talking Mats, PECS) | |  | Other *(please specify)* | | | |
| They are non-verbal | |  | Further details | | | |
| They prefer information in Easy Read | |  |  | | | |
| **Has the person you are referring requested an advocate?** | | | Yes  No | | | |
| **If yes, do they require a same-gender advocate?** | | | Yes  No Don’t know | | | |
| **Has the person agreed to this referral?** | | | Yes  No Lacks capacity to consent | | | |
| **Is there anything we need to know in order to ensure the safety of the person you are referring and of our advocates?** *(Please select all that apply)* | | | | | | |
| 2 to 1 or higher support ratio |  | | Other *(please specify)* |  | | |
| Daily change in risk profile |  | | Further details | | | |
| History of abuse/​assault of professionals |  | |

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| **3. Your Details** | | | | | |
| **Title** | |  | | | |
| **Full name** | |  | | | |
| **Telephone number(s)** | | | **Email address** | | |
| **Organisation** | |  | | | |
| **Address** | |  | | | |
| **Team or department** | |  | | | |
| **Job title (if different)** | |  | | | |
| **Is this the first time you have made a referral to VoiceAbility?** | | Yes  No | | | |
| **If yes, please tell us how you heard about us.** *(Please select all that apply)* | | | | | |
| Choose an item. | Other (please specify) | | |  |  |

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| Diversity monitoring | | | | |
| *We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the person you’re referring, you can help us improve what we offer.* | | | | |
| What are the preferred pronouns of the person you are referring? | | | Choose an item.  If selected - Other (please specify): | |
| What is the gender of the person you’re referring? | | | Is this different from their gender assigned at birth? | |
| Male |  | | Yes |  |
| Female |  | | No |  |
| Non-binary |  | | Don’t know/prefer not to say |  |
| Other |  | |  |  |
| Don’t know/prefer not to say |  | |  |  |
| What is their sexual orientation? | | | | |
| Choose an item. | | | If selected - They prefer to self-describe *(please specify)* | |
| **What is their ethnic group?** | | | | |
| *Asian or Asian British* | | | | |
| Bangladeshi | |  | Pakistani |  |
| Chinese | |  | Another Asian background |  |
| Indian | |  | Don’t know/​prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | |
| African | |  | Another Black background |  |
| Caribbean | |  | Don’t know/​prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | |
| Asian and White | |  | Another Mixed background |  |
| Black African and White | |  | Don’t know/​prefer not to say |  |
| Black Caribbean and White | |  |  |  |
| *White* | | | | |
| British, English, Northern Irish, Scottish, or Welsh | |  | Another White background |  |
| Irish | |  | Don’t know/​prefer not to say |  |
| Irish Traveller or Gypsy | |  |  |  |
| *Another ethnic group* | | | | |
| Arab | | |  | |
| Another ethnic background | | |  | |
| Prefer not to say | | |  | |
| Don’t know/​prefer not to say | | |  |  |
| **What is their religion?** | | | | |
| Choose an item. | | | Other (please state) | |

**Please email the completed form to the usual email address** [**helpline@voiceability.org**](mailto:helpline@voiceability.org)