**Spot Purchase**

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| **Full name:** |  |
| **DOB:** |  |
| **Permanent address:** |  |
| **Current location if different from permanent address:** |  |
| **Telephone number:** |  |
| **Mobile number:** |  |
| **Email address:** |  |
| **Disability or impairment:** | Learning disability  Acquired brain injury  Autistic spectrum disorder  Dementia  Neurological conditions  Stroke  Mental health condition  Sensory impairment  Long term health condition  Physical disability  None  Not listed, **please specify:**  Prefer not to say |
| **Gender:** | Female  Male  Female, Male at birth  Male, Female at birth  Non-binary  Not listed, **please specify:**  Prefer not to say |
| **Pronouns:** | He/him  She/her  They/them |
| **Sexual orientation:** | Bisexual  Heterosexual  Lesbian or gay  Not listed, **please specify:**  Prefer not to say |
| **How does the person communicate?** | English  Other spoken language, **please specify:**  British Sign Language  Words/pictures/Makaton  Gestures/expressions/vocalisations  Not listed, **please specify:**  No obvious means of communication |
| **Ethnic origin:** | Arab/British Arab  Asian/British Asian  Black/Black British  Gypsy/Roma/Traveller  Mixed heritage  White British – English, Welsh, Scottish, N. Irish  White – Irish  White Other  Not listed, **please specify:**  Prefer not to say |
| **Religion or belief:** | Atheist  Baha’i  Buddhist  Christian  Hindu  Humanist  Jewish  Muslim  Pagan  Not listed, **please specify:**  Prefer not to say  No religion or belief |
| **Have you or any of your family served in the armed forces?** | Yes  No |

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| **Referrer’s contact details:** | |
| Name: | Role: |
| Address: | |
| Email: | |
| Telephone number: | Fax: |

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| **Issue to be addressed:** |
| RPR – 4 weekly visits to P (with an RPR update) for contentious cases  RPR – 6 weekly visits to P (with no RPR update) for settled cases cases  IMCA  IMHA  Care Act  Health / Social Care Complaints  Rule 1.2 Representative  Return to Care  Care Leavers  Children’s Advocacy  Child Protection  Other |

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| **Significant dates:** |
| Please provide details for any impending meetings or deadlines: |

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| **Further relevant information:** |
| Please provide details: |

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| **Please provide details of any risk the Independent Advocate will need to consider** |
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| **Consent:** | | |
| Due to GDPR (2018), we need signed authorisation to say that the individual agrees to Advocacy Focus holding personal information (including the information provided on this referral) | | |
| **Does the person have capacity to consent to the referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |

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| **I would like an Independent Advocate to support me:** | |
| Person’s signature: | Date: |

|  |  |
| --- | --- |
| **I would like an Independent Advocate to do this work:** | |
| Referrer’s signature: | Date: |