**1.2 Representative (St Helens)**

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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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| **Significant dates:** |
| Please provide any deadlines in relation to the Court of Protection: |

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| **Further relevant information:** |
| Where possible, please can you provide any relevant Court of Protection documentation.  **Please note that that we also require the most recent care plan from the local authority.** |

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| **Please provide details of any risk the 1.2 Representative will need to consider:** |
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**Consent from Referrer:**

Due to GDPR (2018), we need signed authorisation to say that people agree to Advocacy Focus holding personal information (including the information on this form)

The person being referred is deemed to lack capacity; therefore, the referrer must sign to say they are referring and providing information in the person’s best interests, acknowledging that the person referred lacks capacity to make this decision.

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| I would like a 1.2 Representative to do this work. I am providing this information and asking for this referral in the client’s best interests: | | |
| **Referrer’s signature:** |  | Date: |

**Please email the completed form to: admin@advocacyfocus.org.uk**