**Independent Visitor (St Helens)**

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| **Full name:** |  |
| **DOB:** |  |
| **Permanent address:**  (please include: how long is it envisioned that they will be at this address, are there any risks associated with this 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  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 |

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

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| **Are you aware of any issues or concerns that should be taken into consideration in relation to:** | |  |  |  |  | **Further Details:** |
| **Health** | Physical health | Yes |  | No |  |  |
| Medical conditions | Yes |  | No |  |  |
| Use of medication | Yes |  | No |  |  |
| Pregnancy | Yes |  | No |  |  |
| **Disability** | Disability | Yes |  | No |  |  |
| Learning disability | Yes |  | No |  |  |
| Mobility or access requirements | Yes |  | No |  |  |
| Social and communication requirements | Yes |  | No |  |  |
| Capacity to retain information | Yes |  | No |  |  |
| Capacity to understand complex info | Yes |  | No |  |  |
| **Mental Health** | Mental health | Yes |  | No |  |  |
| Emotional wellbeing | Yes |  | No |  |  |
| Low confidence or self esteem | Yes |  | No |  |  |
| Self-harm | Yes |  | No |  |  |
| Suicide attempts | Yes |  | No |  |  |
| **Vulnerability** | Risk taking behaviour | Yes |  | No |  |  |
| Substance misuse | Yes |  | No |  |  |
| CSE | Yes |  | No |  |  |
| Trafficking | Yes |  | No |  |  |
| Involvement in criminal activity | Yes |  | No |  |  |
| Vulnerable to exploitation | Yes |  | No |  |  |
| Gang involvement | Yes |  | No |  |  |
| Cultural sensitivities | Yes |  | No |  |  |
| **Risk to Others** | Aggressive or violent behaviour to others | Yes |  | No |  |  |
| Inappropriate sexualised behaviour | Yes |  | No |  |  |
| Concerns regarding associates | Yes |  | No |  |  |
| Allegations against staff | Yes |  | No |  |  |
| Supervision/ratio requirements | Yes |  | No |  |  |
| Location of meeting | Yes |  | No |  |  |
| Behaviour | Yes |  | No |  |  |
|  | Other (e.g. reputation issues) | Yes |  | No |  |  |

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

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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 young person have capacity to consent to the referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |

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| **Has the referral been discussed with the parent/carer or guardian and/or the young person?** | Yes  No |
| Further details if appropriate: | |

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| **I would like an Independent Visitor to support me:** | |
| Person’s signature: | Date: |
| Referrer’s signature on behalf of the person: | Date: |

**Please return this referral form to** [**admin@advocacyfocus.org.uk**](mailto:admin@advocacyfocus.org.uk)