

Dumfries and Galloway Advocacy Service Referral Form

Referrer Details

Name		Office Tel Number	
Service		Mobile Tel Number	
Role (SW, MHO, NHS etc.)		Email	
Date Referred		How did you hear about our service?	

I confirm that the client has consented to their details being passed to Dumfries and Galloway Advocacy Service and for contact to be made.

Client Details

Client Title and Name		Date of Birth	
Address			
Post Code		Gender	
Home Tel Number		Email	
Mobile Tel Number		Preferred method of contact	

Type of Accommodation

Homeowner		Hospital		Homeless		Other	
Private Tenant		Care Home		Hostel		Undisclosed	
Social Housing		Supported Accom.		Traveller			

Ethnicity

White Scottish		Bangladeshi		Black Scottish		African	
White Other UK		Indian		Black Other		Mixed race	
White Irish		Pakistani		Caribbean		Unknown	
White European		Chinese		Other South Asian		Other	

Guardianship / Named Person / POA / Named Person

Welfare Guardianship		Financial Guardianship		Power of Attorney		Named Person	
If yes to any of the above please give details							

www.dgadvocacy.co.uk



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Risks							
Violent		Aggressive		Exploitative		Sex Offender	
Misusing Substances		Child Protection		Awaiting Trial		Risk to Self	
Adult Survivor of Childhood Sexual Abuse		Domestic Abuse		Notifiable Disease		Other Risks	
If yes to any of the above please give details							

Additional Information

GP Surgery							
Mobility Issues							
Communication / Literacy Issues							
Has the referrer informed client they are making referral?							
Mental Health		Learning Disability		Physical Disability			
Families at Risk		Substance Misuse		Health Primary / Secondary			
Domestic Abuse		Carer		Older Adult			
Other							
Brief Description of Issue:							

Please send completed forms to:

Email: info@dgadvocacy.co.uk

Office Use Only – Method of Contact / Previous Client

Phone		Drop-in		Has client been with us previously	
Email		Website Contact		Previous Client Number/s	
Letter		Surgery		Date/s closed	
Client ID				Allocated Advocate	

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