Dumfries and Galloway Advocacy Service Referral

Referrer Details			
Name		Office Tel Number	
Name of Service		Mobile Tel Number	
Role (SW, MHO, Nurse, etc.)		Email Address	
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 and Ward (if applicable)			
Post Code		Gender	
Home Tel Number		Email Address	
Mobile Tel Number		Preferred method of contact	

Type of Accommodation (tick one)							
Homeowner		Hospital		Homeless		Other	
Private Tenant		Care Home		Hostel		Undisclosed	
Social Housing		Supported Accomm		Traveller			

Ethnicity							
White Scottish		Bangladeshi		Black Scottish		African	
White Other UK		Indian		Black Other		Mixed Race	
White Irish		Pakistani		Carribean		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, please give name and contact details.							

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					
Name of GP Surgery					
Details of any Mobility Issues					
Details of Communication and/or Literacy Issues					
Has the client been informed of this referral? (If not, why?)					
Mental Health		Mental Health 65+		Self-Directed Support	
Autism / ADHD		Learning Disability		Adults with Incapacity	
18-25 yr old		Unpaid Carer		Adult Support & Protection	
Enquiry					
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	