



ADVOCACY SERVICE SELF REFERRAL FORM

Date of referral:

SN #

CLIENT DETAILS	Name:	D.O.B:
Address:		
Phone no: (please indicate the best time to call)		
Email:	Safe to: post / email / text / leave voicemail? (please circle)	
Preferred method of contact:	Where did you hear about the Advocacy Service?	

How would you describe your ethnic origin?	
<u>White</u> English/Northern Irish/Welsh,/Scottish Irish Gypsy or Irish Traveller Any other white background (please give details)	<u>Black or Black British</u> African Caribbean Any other black background (please give details)
<u>Asian or Asian British</u> Bangladeshi Indian Pakistani Chinese Any other Asian background (please give details)	<u>Mixed</u> Asian and white Black African and White Black Caribbean and White Any other mixed background (please give details)
<u>Other ethnic Group</u> Arab Any other ethnic group (please give details)	Prefer not to say

Which of the following best describes your sexual orientation?	
Heterosexual/straight	Lesbian/gay woman
Gay man	Bisexual
Other (please state)	Prefer not to say

What gender are you?			
Male	Female	Other (please state)	Prefer not to say

Do you have any additional needs? Eg Mental health problems? Substance misuse? Learning difficulties? Please give details
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Do you have any concerns about your safety? Please give details.

-If you or someone else is in immediate risk of harm please call 999-

Has the incident been reported or are you considering reporting to the police?

Are there any other needs/special requirements (such as child care, learning difficulties, an interpreter, accessibility issues, contact at specific times of day, relevant mental health issues, potential risks to staff or yourself) that need to be considered?

What support are you looking for from the Advocacy Service?

Any additional information: