

**MHM Wales Advocacy Services**

**Independent Professional Advocacy (IPA)**

**Referral Form**

**Tel :** 01656 649557 **Email:** ipa@mhmwales.org

![BCBC_logo_-_generic[1] - AIM2TRI]()

**MHM Wales’ Commitment to Confidentiality:**

Information given to MHM Wales’ Professional Independent Advocacy Service will be processed in accordance with the UK Data Protection Act 2018 which replicates the requirements of GDPR into UK legislation.

The role of the IPA under [Part 10 of the Social Services Wellbeing Act 2014](http://gov.wales/docs/dhss/publications/151218part10en.pdf) is specific and **does not** include: Befriending; Counselling; Mediation; Providing Advice or Legal Support.

|  |
| --- |
| **Details of person being referred to the Independent Professional Advocacy Service** |
| Full Name: |  |
| Date of Birth: |  |
| Age: |  |
| Gender: |  |
| Address: |  |
| Area currently residing: |   |
| Contact Number: |  |
| Email: |  |

**Are there any risks associated with this referral?**

[ ]  YES [ ]  NO

**If yes, please give details**

|  |
| --- |
|  |

**Client needs Advocacy for the following reason/issue:**

|  |  |  |
| --- | --- | --- |
| [ ]   **Assessment, Care and Support Planning, Reviews** | [ ]  **Safeguarding**Suspected of being at risk of harm or neglect, subject to safeguarding concerns including enquiries under section 126 and or 127 and or 128 of the Act. | [ ]  **Accessing Information,** **Advice and Assistance** |
| **External Factors impacting on their care and support arrangements.** [ ]  Accommodation issues (inc. Care Homes) [ ]  Concern/ dissatisfaction / complaint [ ]  Change of service type / Preparing to leave hospital and return to the community. [ ]  Other (please specify below)  |

**Please ensure your client is eligible to seek an IPA by confirming which barriers they face:**

|  |  |
| --- | --- |
| [ ]  Understand Relevant Information  | [ ]  Retain Information  |
| [ ]  Use or Weigh Information  | [ ]  Communicate Views Wishes & Feelings  |

**Client Group**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Sensory Impairment | [ ]  Mental Health | [ ]  Dementia | [ ]  Physical Disability |
| [ ]  Learning Disability | [ ]  Parents of ChildrenAgreed allocated hours…………………………. | [ ]  OtherPlease state: |

**What is the person’s primary method of communication?**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Welsh | [ ]  English | [ ]  BSL | [ ]  Another Spoken LanguagePlease state:  |
| [ ]  Gesture/ vocalisations/ facial expressions | [ ] No obvious means of communication | [ ]  Other |

**Ethnic Background**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  White British | [ ]  White Irish | [ ]  White/ Asian | [ ]  Black Caribbean  |
| [ ]  White/ Black Caribbean | [ ]  Bangladeshi | [ ]  Indian | [ ]  Chinese |
| [ ]  Mixed Background | [ ]  Black African | [ ]  Pakistani | [ ]  Other Ethnic Group |

**Has referral been discussed and agreed by person?** [ ]  YES [ ]  NO

**How can the IPA Service assist this person to achieve personal outcomes?**

**Child Protection Referrals only**

1. **Is the adult being referred a parent being assessed with public or private law proceedings?**

 [ ]  Public Law [ ]  Private Law

1. **Are care proceedings being initiated/ongoing?**

[ ]  YES [ ]  NO

1. **Are there any further assessments being undertaken?**

[ ]  YES [ ]  NO

If yes, please state ……………………………………………..

1. **Is the adult being referred a parent to a child who is on the Child Protection Register (but not in PLO or Court)?**

[ ]  YES [ ]  NO

1. **Is there another parent/carer that requires advocacy support in relation to the same case? \****If another parent/carer involved requires advocacy support, please complete separate referral at (* [*www.mhmwales.org*](http://www.mhmwales.org) *)\**

[ ]  YES [ ]  NO

1. **Has the other parent/carer involved been referred for advocacy support?**

[ ]  YES [ ]  NO

**Additional Services**

**Would the client be interested in accessing other support services alongside advocacy support?**

[ ]  YES [ ]  NO

**If yes, what type of service would be of interest?**

|  |  |
| --- | --- |
| [ ]  Counselling Service  | [ ]  Self-Harm Peer Support Group |
| [ ]  Eating Disorder Peer Support Group |  |

**Other Contacts**

**Please provide details of anyone else who knows the person well or involved with the client. This can be a professional or family member. Consent must be sought by the person before sharing their contact details and completing the below box.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name |  |
| Relationship to client |  | Relationship to client |  |
| Telephone number |  | Telephone number |  |
| Email |  | Email |  |

|  |
| --- |
| **Referring Organisation:**  |
| **Name:**  | **Job Title:**  |
| **Address:**  | **Telephone number:**  |
| **Mobile:**  |
| **Email address:**  |
| **Date of Instruction:** |