**Parents Advocacy Referral Form**

Parents Advocacy assists parents, who have a difficulty being involved in the process to fully engage in assessments and to understand the complex statutory processes within Children’s Social Care, where there is no one appropriate or available to facilitate and represent their views. The provision aims to build the individuals confidence and self-esteem.

Referrals will be accepted from the following Stoke-on-Trent City Council Social Care Staff and MUST be signed by the Authorising Manager: *Principal Managers, Practice Managers, Social Workers, Assistant Social Workers, Conference and Review Managers, Independent Reviewing Officers.*

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| 1. **Eligibility.** | | | | | | | | | |
| **Parents must meet the following criteria:**   1. *Their child or children must be open to Stoke-on-Trent’s Social Care team.* 2. *The person requiring support has Learning Disabilities/Autism/Complex Needs which lead to them having a substantial difficulty in the following areas:*  * *Understanding relevant information* * *Using or weighing up information.* * *Retaining information.* * *Communicating their views, wishes and feelings; and* * *There is no on appropriate or available to facilitate the persons active involvement in the process.* | | | | | | | | | |
| 1. **About the person requiring support.** | | | | | | | | | |
| **Mrs/Mr:** | **Name:** | | | | | | **Date of birth:** | | |
| **Tel:** | **Email:** | | | | | | **Mobile:** | | |
| **Current Address:**  **Postcode:** | | | | | | | | | |
| Social Services P number: | | | | | | | | | |
| I confirm the person has no-one APPROPRIATE or available to facilitate involvement | | | | | | | | |  |
| 1. **How does this person communicate?** | | | | | | | | | |
| Preferred Language: | | | | | | Dialect: | | | |
| Spoken Language | | |  | | | Words/Pictures/Makaton | | |  |
| British Sign Language | | |  | | | Gestures/Facial Expressions/Vocalisations | | |  |
| Other, please give details: | | | | | | | | | |
| **Known risks (to themselves or others):** Please include if the person is currently on a Covid positive ward, any historical risks, etc | | | | | | | | | |
| 1. **What are the person’s additional support needs?** | | | | | | | | | |
| Mental Health problems | | | |  | | Physical Health | | |  |
| Cognitive Impairment | | | |  | | Autism Spectrum Condition | | |  |
| Learning Disability | | | |  | | Serious Physical Illness | | |  |
| Other: | | | | | | | | | |
| 1. **Nature of Substantial Difficulty (please tick all that apply).** | | | | | | | | | |
| Understand relevant information | | |  | | | Retaining information | | |  |
| Using or weighing up information | | |  | | | Communicating their views, wishes and feelings | | |  |
| I can confirm that the relevant person has had a capacity assessment (Please attach to referral) | | | | | | | | |  |
| 1. **What process does the person require support with? (Please tick).** | | | | | | | | | |
| Child Protection | |  | | | Child in Need | |  | | |
| Care Proceeding | |  | | | Public Law Outline | |  | | |
| Other: | | | | | | | | | |
| Are or will CSC or CSS be involved?  Yes  No | Team: | | | | CIC  CSS | | | Other: | |
| 1  2  3  4  5 | | |
| Name of CSC or CSS Social Worker/ Assessor: | | | | | | | | | |
| Email: | | | | | Tel: | | | | |
| 1. **Additional information.** | | | | | | | | | |
| **Please give details of any forthcoming meeting dates.**  Please include location, the issue, times, dates, in person or via Zoom or Teams, what is the meeting for? Are other professionals attending? | | | | | | | | | |
| **What steps need to be taken to maximise the person’s full participation?** e.g., consider mental capacity, sensory or autism related needs, confidence, information and advice or communication aid, interpreters, time of day, medication effects, suitable environment, etc | | | | | | | | | |
| **Is there any other information that you believe to be relevant to this referral?**  Are there any other professionals involved in the referral? Solicitors, other parents/ family, Intermediaries, | | | | | | | | | |

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| 1. **Diversity Monitoring.** | | | | | |
| **By completing the information below you can help us ensure our services reach everyone who needs them and inform how we might improve our service provision.** | | | | | |
| **What is the person’s gender?** | | | | **Is the person’s gender different from that assigned at birth?** | |
| Male | | |  | Yes |  |
| Female | | |  | No |  |
| Non-binary | | |  | Don’t know/prefer not to say |  |
| Don’t know/prefer not to say | | |  |  |  |
| Person’s own description: | | | |  |  |
| **What is the person’s sexual orientation?** | | | | | |
| Heterosexual/straight | | |  | Gay woman/lesbian |  |
| Bisexual | | |  | Don’t know/prefer not to say |  |
| Gay man | | |  | Person’s own description: | |
| **What is the person’s ethnic group?** | | | | | |
| *Asian or Asian British* | | | | | |
| Bangaldeshi | | |  | Pakistani |  |
| Chinese | | |  | Another Asian background |  |
| Indian | | |  | Don’t know/prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | | |
| African | | |  | Another black background |  |
| Caribbean | | |  | Don’t know/prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | | |
| Asian and White | | |  | Another Mixed background |  |
| Black African and White | | |  | Don’t know/prefer not to say |  |
| Black Caribbean and White | | |  |  |  |
| *White* | | | | | |
| English/Welsh/Scottish/Northern Irish/British | | |  | Another White background |  |
| Irish | | |  | Don’t know/prefer not to say |  |
| Irish Traveller or Gypsy | | |  |  |  |
| *Another ethnic group* | | | | | |
| Arab | | |  | Don’t know/prefer not to say |  |
| Another ethnic background | | |  | Person’s own description: | |
| **What is the person’s religion?** | | | | | |
| No religion | | |  | Hindu |  |
| Christian (all denominations) | | |  | Muslim |  |
| Buddhist | | |  | Other (please state) |  |
| Jewish | | |  | Don’t know/prefer not to say |  |
| Sikh | | |  | Person’s own description: | |
| **Does the person identify as having a disability or long-term health condition?** | | | | | |
| Yes | No | Please specify: | | | |

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| 1. **Children’s Social Care (CHC) Assessor’s Details.** | | | | |
| Are or will CHC be involved? | Team: | | | |
| Name of referrer: | Organisation: | | | |
| Email: | Tel: | | | |
| 1. **Social Worker’s / Referrer’s Details.** | | | | |
| Name of referrer: | Job Title: | | | |
| Team: | Organisation: | | | |
| Email: | Tel: | | | |
| Date of Referral: | How did you hear about us: | | | |
| 1. **Managers Authorisation.** | | | | |
| Team Managers Name: | Team/ Organisation: | | | |
| Email: | Tel: | | | |
| Team Managers Signature *(electronic):* | | | Date: | |
| 1. **Consent.** | | | | |
| Have you discussed this referral with the person being referred? | | Yes | | No |
| Has the person agreed to this referral being made? | | Yes | | No |
| **Disclaimer** | | | | |
| **Please note that we may not be able to attend all meetings listed on the referral form. Where possible, provide us with 2 weeks-notice for any meetings to allow the advocate adequate time to support the advocacy partner.** | | | | |
| **The referrer is responsible for providing ASIST with accurate, up to date information and contact details, and updating ASIST with any new information or, amendments to information provided on the referral form after it has been submitted. PLEASE make sure information is correct before submitting this form.** | | | | |
| **To discuss a referral please contact Asist on 01782 845584**  **Fill in this form and send to Asist by emailing** [**referrals@asist.co.uk**](mailto:referrals@asist.co.uk)  **Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW.** | | | | |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

