Advocacy for All
Hill House
Bishopsford Road
Carshalton
SM4 6BL

Tel: 0345 310 1812

Email: groups@advocacyforall.org.uk

Web: www.advocacyforall.org.uk

Sutton Touchbase Project

Referral Form

The Sutton Touch Base Project

You can use this project if you:

- an adult (over 18 years of age)
- live in the Sutton borough
- have a learning disability and mental health needs

You can't use this project if you

- are in crisis
- need clinical intervention.

If you are **feeling unsafe** and **need urgent help**, please **call 999**

What We Offer:

- 6 weeks **1:1 Self-Advocacy** either face-to-face or remotely
- a confidential, **safe space** to discuss what is going on for you
- support with **understanding your rights** and responsibilities
- **peer support group**
- **drop in and chat sessions**
- **signposting** to other relevant services and forms of support

If you cannot fill in this form, please click 'view' then 'edit'.

Once completed send to groups@advocacyforall.org.uk or post to the above address.

Please fill in all the boxes, where possible. If information is missing it may take longer to process your referral

Personal Details:

Title:

Full Name:

Pronouns:

Date of Birth:

Address:

Postcode:

Tel:

Mobile:

Email:

Please select ALL those which apply:

Have a learning disability ☐

Live in the Sutton borough ☐

Mental Health Difficulties ☐

Professional Involvement Details:

We will only contact other organisations with your explicit consent or if we need to relay a specific concern as part of our duty of care.

Please ask if you need further details.

GP's Name (if known):

GP Surgery:

GP Address:

GP Telephone Number:

Named Social Worker (if any):

Contact Preferences:

By submitting this referral form, you agree that the information included on this form can be stored and processed for the purposes of providing our service.

It will be stored securely and electronically, according to our Privacy Statement.

How would you like us to contact you?

(Please choose at least one)

Landline Call	Mobile Phone Call	Text Message	Email
☐	☐	☐	☐

Please state the reason for referral and any background information:

Please give as much detail as possible about why this referral is being made. What are your main reasons for wanting to access the Sutton Touch Base Programme?

Risk Information:

Please give details about any risk factors that may be involved, of which Advocacy for All may need to be aware.

Please be honest and answer fully, to the best of your knowledge. We want to make sure that we provide the right level of support and that everyone feels safe when working with us. The presence of risks does not mean that the service will necessarily be declined.

Any inaccurate or incomplete information may affect our ability to offer a suitable service.

Is there any current or historical risk of:

If any risk present, this referral will need to be screened prior to membership being offered.

Suicidal thoughts and feelings?	☐	Alcohol or substance misuse?	☐
Self-harm?	☐	Difficulties controlling anger or violence?	☐
Criminal charges?	☐	Restrictions on accessing some services or locations?	☐
Criminal convictions?	☐	Other risk that we may need to know about?	☐

If you have answered 'Yes' to any of the questions, please give more details:

Additional Information:

Monitoring Data: *(Optional)*

We use this data to try to make sure that our work is as inclusive as possible. We want to make sure that our resources are used fairly and with maximum impact.

Gender: Please choose
Ethnicity: Please choose
Religion/Faith: Please choose
Sexuality: Please choose

Additional Medical Information:

(e.g.: allergies, neurodiversity (other than learning disability), medical conditions, physical limitations, mental health conditions etc.)

Emergency Contact Information:

We will only contact this person in urgent circumstances.
Please check that they give consent for their information to be shared.

Name:

Relationship to You:

Telephone Number:

Date of referral:	**Is this a self-referral?** Yes

Referrer's Details:

(Do not complete if a self-referral)

By submitting this referral form on behalf of an individual, the referrer is agreeing to the following:

*I confirm that I have **informed consent** from the person being referred to make a referral to Advocacy for All.*

*I have completed this referral form **fully and to the best of my knowledge**.*

I agree: ☐

Please tick here if the person being referred has given consent for the referrer to be informed about the outcome of the referral: ☐

Referrer's Name: **Relationship to Client:** *If this referral is from a professional organisation:* **Job Title:** **Organisation:**	**Address:** **Postcode:** **Landline:** **Mobile:** **Email:**