****Independent Professional Advocacy
**Self-Referral Form**

**E-mail**: IPA@mhmwales.org **Telephone**: 01656 651 450

**MHM Wales’ Commitment to Confidentiality:**

Information given to MHM Wales’s 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.”

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| **Details of person being referred to the Independent Professional Advocacy Service** |
| Full Name:  | Address:  |
| Area currently residing:[ ]  Lynfi Valley [ ]  Garw Valley [ ]  Ogmore Valley [ ]  Pencoed[ ]  Pyle/Kenfig/Cornelly [ ]  Bridgend [ ]  Porthcawl [ ]  Valleys Gateway  |
| **Contact Number** Home : Mobile:  Email:  |
| **Date of Birth:** **Age:** **Gender**: [ ]  Male [ ]  Female  | **Are there any risks associated with this referral?** |

Access to IPAs will **ONLY** be arranged where **no other appropriate individual** (including the person themselves) is able to represent that person’s views, wishes and feelings. Please ensure your client is eligible to seek an IPA*.* 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.

**Has the referral been reviewed by the** [**advocacy information Hub**](http://thearmspark.eu/bvandc/index2.php) **for other appropriate services?**

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| What other referral options were considered? |

[ ]   **No** [ ]   **Yes**

**My Client needs Advocacy for the following reason/issue (please tick🗸)**

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| [ ]  | **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)*  |

**Client Group**

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| [ ]   **Sensory Impairment** | [ ]    **Mental Health** | [ ]    **Dementia** | [ ]    **Physical Disability** |
| [ ]    **Learning Disability** | [ ]   **Other** | **Please state:** |

**Barriers faced by the client which require an IPA as they impair the individual’s ability to:**

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

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

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

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| **What is the person’s primary method of communication?**[ ]  Welsh [ ]  English [ ]  Another Spoken Language [ ]  BSL [ ]  Other[ ]  Gesture/ vocalisations/ facial expressions [ ] No obvious means of communication**Ethnic Background**[ ]  White British [ ]  White Irish [ ]  Black Caribbean [ ]  White/ Asian[ ]  White/ Black Caribbean [ ]  Bangladeshi [ ]  Indian [ ]  Chinese[ ]  Mixed Background [ ]  Black African [ ]  Other Ethnic Group [ ]  Pakistani |

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