**Community Advocate Referral Form**

Hammersmith and Fulham Mencap

99 Addison Gardens

W14 0DT

Tel: 020 8748 5168

**Please complete this form and return it to Deborah David**

**deborah.david@hfmencap.org**

**Date of referral:**

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| **Referral requested for:** |
| **Name** |  |
| **DOB** |  |
| **Address** |  |
| **Postcode**  |  |
| **Contact Telephone** |  |
| **Email** |  |
| **Gender** |  |

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| **If you are filling this form for someone else please fill in the box below.** |
| **Name** |  |
| **Relationship to Referee** |  |
| **Contact Telephone** |  |
| **Email** |  |
| **Address*****(If different to person referral being requested for)*** |  |
| **Postcode *(If different to person referral being requested for)*** |  |
| **Has the person being referred, agreed to this referral?**  |  |

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| **GP Name** |  |
| **GP Address & Postcode** |  |

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| **Language Spoken** |  |
| **Interpreter Required** |  **YES NO** |

**Please select from the following options:**

1. Person being referred is 18 years or over living in the borough of Hammersmith and Fulham. YES NO
2. Person being referred meets one or more of the following criteria. Please tick all the relevant options that apply:
* People with learning disabilities and/or autism
* People with mental health problems
* People with a brain injury
* People with physical disabilities
* People with sensory impairments (sight and hearing problems)
* Older people and people with dementia
* People with a long-term illness
* People with profound and multiple disabilities or complex health needs

 I would like an advocate because…..

(Please write as much information as possible. Use another sheet if you want to)

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**Please list any other agencies currently involved/involved in the past with the adult – include name of organisation and contact details:**

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