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**47 CAUSEYSIDE STREET, PAISLEY PA1 1YN**

**Telephone: 0141 849 1229 Email:** **referrals@youfirstadvocacy.org**

Tribunal Referral Form

Title \_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_ National Insurance No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mob\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital & Ward\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tick box that best describes the Category:**

Mental Health 🞏 Learning Difficulties 🞏

Physical Disabilities 🞏 Older Person 60+ 🞏

Emergency Contact Person 🞏 Named Person 🞏 (please tick)

Title \_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mob \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP/Surgery Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Consultant Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Details of Medical/Health Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REFERRER NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESIGNATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POST CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Person Aware of the Service and in Agreement to Referral? Yes 🞏 No 🞏

**Is there any preference for an advocate?**

Male 🞏 Female 🞏 No 🞏

**P.T.O.**

REFERRER NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESIGNATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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POST CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPGHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is The Person Aware of the Service and in Agreement to Referral? Yes 🞏 No 🞏

Reason for Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for Referral** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DETENTION/TRIBUNAL INFORMATION (where applicable):**

Name of Responsible Medical Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Mental Health Officer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there an Advance Statement? Yes 🞏 No 🞏 Don’t Know 🞏

Detention Type: Long Term 🞏 Short Term 🞏 Other 🞏

Date of detention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has legal representation been requested? Yes 🞏 No 🞏

If YES, please provide name of Lawyer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NO, does client require one? Yes 🞏 No 🞏

**RISK ASSESSMENT**

Is there information regarding risk that our agency needs to be aware of (please tick)

Suicide Self Harm Yes 🞏 No 🞏

Aggression/Violence Yes 🞏 No 🞏

Drug/Alcohol Issues Yes 🞏 No 🞏

Other Information that may be relevant:-

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Risk Assessment Completed by: Name: Designation

**Relevant agencies involved:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use**

Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New Referral ⁯ Re-Referral ⁯ One off ⁯

Date Allocated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advocate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Closed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15/04/2020**