**Referral Form for Independent Advocacy**

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| **Locality (please note this service is available to Aberdeenshire residents)** |
| **Aberdeenshire** | Proof of residency will be requested |

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| **Who is the referral for?**  |
| **Name** |  |
| **Date of Birth** | (Service available for 16 plus) |  |
| **Address** |  |
| **Email Address** |  |
| **Phone Number** |  |
| **Referring for self?**  | Yes |  | No |  |

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| Person making referral (if not self-referral) |
| **Name** |  |
| **Relationship to the individual** |  |
| **Organisation** |  |
| **Do you have consent of the individual?**  | Yes |  | No |  | Unable to Consent |  |
| **Details if Unable to Consent** |  |
| **Address** |  |
| **Email Address** |  |
| **Phone Number** |  |

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| Communication Preferences (How would you like to meet with your advocate?) |
| **In Person at home** |  |
| **In Person at Carnie Drive Premises** |  |
| **Teams Call** |  |
| **Email Contact** |  |
| **Phone Call** |  |
| **Preferred Times?** |  |

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| **What would you like support with?**  |
| **What is the main issue?** (Information about the need for advocacy support) |

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| Dates/Times of important Meetings (if any)  |
| **Type of Meeting** |  |
| **Date** |  |
| **Time** |  |
| **In Person/Teams** |  |

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| **What would you like to achieve through advocacy?**  |
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