

**Parent Advocacy**

**Self-Referral Form**

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| **Name:** |  | **DOB:** | **Ethnicity:** | **Gender**: |
| **Home address:** |  |
| **Telephone:** |  | **Mobile:** |  |

|  |  |
| --- | --- |
| **Contact details of family member** **or friend:**(optional) |  |

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| --- | --- |
| **Contact details of professionals** **involved:** (for example: child’s social worker, mental health worker, solicitor) |  |

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| **Please tell us if you have any meetings or appointments to attend:**  |

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| **Please tell us how you would like us to keep in touch with you:** (For example face to face, text, phone, BSL) |

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| **Please tell us if you have any specific needs we need to be aware of:**(For example: physical disability, learning disability, mental health needs, sensory impairment) |

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| **Is there any other information that would help your advocate to support you?****An** |

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**Consent Form – Please tick a box**

**I give permission** formy advocateto act on my behalf and in my interest in relation to the advocacy support I am receiving

Yes No

**I give permission** for my detailsand informationrelating to my situation/issues to be held at the Speak Up Advocacy Hub.

Yes No

**I give permission** for my advocateto speak to other organisations to obtain relevant information and to keep copies of relevant documents.

Yes No

I **give permission** for other parties who hold this information to provide it to my advocate.

Yes No

 **Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By requesting advocacy support you give consent to Warrington Speak Up holding and sharing information as required for the purpose of providing the service.