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

**E-mail**: [IPA@mhmwales.org](mailto: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:**

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| **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:** | |