**Parent Advocacy Referral Form**

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| Date: | | | | | Ref No: | |
| **Details of the Person Being Referred for Advocacy Support:** | | | | | | |
| First Name: | | Surname: | | | Date of Birth: | |
| Ethnicity: | | | Language (if not English): | | | |
| Gender: | | | Sexuality: | | | |
| Address: | | | | | | |
| Post Code: | Phone Number: | | | Email: | | |
| Significant Medical Conditions (including mental health): | | | Disabilities: | | | |
| Physical Disability | | | Yes / No |
| Sensory Impairment | | | Yes / No |
| Learning Disability | | | Yes / No |
| Dementia/Cognitive/Memory | | | Yes / No |
| Other: | | | |
| **Stage of intervention (CIN, CP Plan, PLO, Proceedings)**: | | | | | | |
| **Is an ICO in place: Yes / No** | | | | | | |
| **Additional Information (Please include any risks we should be aware of such as lone working restrictions):**  **Has the client had a CFA (Cognitive Functioning Assesment)? Please attach a copy to the referral where possible.** | | | | | | |
| **Please let us have details of any dates of upcoming meetings so we can ensure an Advocate is available.** | | | | | | |
| **Involvement of Other Agencies** | | | | | | |
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| **Details of Person Making this Referral** | | | | | | |
| Name: | | | Position: | | | |
| Agency/Team: | | | | | | |
| Contact No: | | | E-Mail: | | | |
| Manger/Ops Lead: | | | E-Mail | | | |
| **Funding Arrangements** | | | | | | |
| Our Hourly Rate is £33.00 (plus VAT). Travel time to meetings will be charged at the same rate and billed in real time. We bill in 0.25 hour increments.   * Mileage is payable at a rate of 45p per mile for meetings attended outside of CV1-CV6. * VAT will be charged on invoices from 01 April 2023. * Parking is charged at cost if needed. * Late payment interest will be applied if we do not receive payment within 30 days. * Cancelled meetings will be chargeable when less than 24 working hours’ notice is given.   **Please confirm below agreed funding for the following :-**  Home Visits  Social Care Meetings (Core Groups/Conferences/LAC Reviews etc)  Parenting Assessments  Solicitors Meetings  Court Hearings  ***We do not accept referrals for individual meetings as this is not in the best interests of the client.***  ***Please select the funding areas approved. If attendance is*** ***required at any meetings outside of above remit, we will contact you directly to confirm funding*** ***is agreed prior to attending.*** | | | | | | |
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| Please ensure client confidentiality and e-mail your completed form to helen@coventryadvocacy.org.uk | | | | | | |