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**Independent Professional Advocacy  
Referral Form**

**E-mail**: [ipa@mhmwales.org](mailto:ipa@mhmwales.org) **Telephone**: 0300 102 4970

**MHM Wales’ Commitment to Confidentiality:**

Information given to MHM Wales’ 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.

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.

Please ensure your client is eligible to seek an IPA *by confirming which barriers they face:*

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| **Understand Relevant Information** | **Retain Information** |
| **Use or Weigh Information** | **Communicate Views Wishes & Feelings** |

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| **Details of person being referred to the Independent Professional Advocacy Service** | |
| Full Name: | Address: |
| Area currently residing: | |
| **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.

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| What other referral options were considered? |

**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** | **Parents of Children** | | **Other** | **Please state:** |

**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:** | |