**Please send this document as soon as possible to allow the advocate time to consult with parents and or prioritise caseloads. Please complete the following and return to:**

[batias.grays@batias.com](mailto:batias.grays@batias.com) [kate.knight@batias.com](mailto:kate.knight@batias.com) **and** sam.emerton@batias.com

**Main Parent details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: |  | | | | | | | | | | | | |
| First Name: |  | | | | | | | | | | | | |
| Middle Name/Initials: |  | | | | | | | | | | | | |
| Surname: |  | | | | | | | | | | | | |
| DOB: |  | | | | | | | | | | | | |
| Gender: | Male |  | | Female | F | Transgender: | | | M to F |  | F to M | |  |
| Potential Risk: | Yes | |  | | No | |  | | | Not known | |  | |
|  | Need two professionals for first visit | | | | | | Yes |  | | no | |  | |

**Contact address.**

|  |  |
| --- | --- |
| Building Name/Number: |  |
| Street: |  |
| Town/City: |  |
| County: |  |
| Postcode: |  |

**Contact Telephone Numbers/Email Address**

|  |  |
| --- | --- |
| Telephone (Home): |  |
| Telephone (Mobile): |  |
| Email Address: |  |

**Emergency Contact**

|  |  |
| --- | --- |
| Name: |  |
| Relationship to Client: |  |
| Telephone: |  |

**Client Profile**

|  |  |
| --- | --- |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ethnic Origin: | White/ British |  | White/ Other | | |  | Arab | |  | | Asian/ British |  |
| Asian/ Other |  | Black/ British | | |  | Black/ Other | |  | | Chinese |  |
| Middle Eastern |  | Mixed race | | |  | Other give details | |  | | | |
| Religion/Faith: | Unknown / not disclosed |  | Atheist | | |  | Buddhist | |  | | Christian |  |
| Hindu |  | Jewish | | |  | Muslim | |  | | Sikh |  |
| Sexuality: | Unknown / not disclosed |  | Heterosexual | | |  | Homosexual | |  | | Bisexual |  |
| Marital Status: | Unknown / not disclosed |  | Relationship | | | x | Single | |  | | Widowed |  |
| Separated |  | Divorced | | |  | Married/civil partnership | | | | |  |
| Older Person: | Yes | | |  | No | | |  | | Not known | |  |
| Wheelchair User: | Yes | | |  | No | | |  | | Not known | |  |
| Communication Difficulties: | Yes | | |  | No | | |  | | Not known | |  |
| If Yes, Give Details: |  | | | | | | | | | | | |
| Interpreter Required (To be sourced By Local Authority) | Yes | | |  | No | | | x | | Not known | |  |

**Impairments/Vulnerabilities/Medical Conditions** Select All That Apply:

|  |  |
| --- | --- |
|  | Acquired Brain Injury - Stroke |
|  | Acquired Brain Injury - Trauma |
|  | Acquired Brain Injury - Other |
|  | Autism Spectrum Condition |
|  | Cancer |
|  | Cerebral Palsy |
|  | Chronic Fatigue Syndrome |
|  | Cognitive Impairment - Mild |
|  | Cognitive Impairment - Moderate |
|  | Cognitive Impairment - Severe |
|  | COPD |
|  | Cystic Fibrosis |
|  | Diabetes |
|  | Dementia |
|  | Down's Syndrome |
|  | Drug/Alcohol Issues |
|  | Fibromyalgia |
|  | Fragile X |
|  | Learning Disability |
|  | Mental Health Issues |
|  | Multiple Sclerosis |
|  | Osteoarthritis |
|  | Osteoporosis |
|  | Physical Disability |
|  | Sensory Impairment - Blind |
|  | Sensory Impairment - Deaf |
|  | Sensory Impairment - Deafblind |
|  | Sensory Impairment - Other |
|  | Serious Long-Term Condition/Illness |
|  | Substantial Difficulty |
|  | Williams Syndrome |
|  | Other - Unspecified Chronic Condition(s) |

|  |  |
| --- | --- |
| Give Details: |  |
| NHS Number: |  |

**Extended Client Profile**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Known To Adult Social Care: | Yes |  | No |  |  |  |
| Lives Alone: | Yes |  | No |  | Not known |  |
| Has Access To Transport: | Yes |  | No |  | Not known |  |
| Behaviours considered to be challenging: | Yes |  | No |  | Not known |  |
| If Yes, Give Details: | Fiona has poor impulse control and poor emotional regulation which can manifest as aggression. | | | | | |
| Disability: | Yes |  | No |  | Not known |  |
| If Yes, Give Details: |  | | | | | |

**Housing**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Housing Type: | Unknown / not disclosed |  | Council Rented |  | Homeless | |  | Housing Association |  |
| Mobile Home |  | Owner- Occupier |  | With family / family owned | |  | Private Rented |  |
| Wheelchair Accessible: | Yes |  | No |  | | Not known | | |  |
| Walking Frame Accessible: | Yes |  | No |  | | Not known | | |  |

**Other professionals involved.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Childs Social Workers, Team manager | Name and email |  | Work mobile number |  |
| Office number |  | Professional address |  |
| School | Name and email |  | Work Mobile number |  |
| Office number |  | Professional address |  |
| Other (Specify) | Name and email |  | Work Mobile number |  |
| Office number |  | Professional address |  |
| Other (Specify) | Name and email |  | Work Mobile number |  |
| Office number |  | Professional address |  |
| Health Visitor | Name and email |  | Work Mobile number |  |
| Office number |  | Professional address |  |

**Referral Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Issue(s): |  | | | | | |
| Reason for referral / request: |  | | | | | |
| Client Service Group: | Learning disability |  | Mental Health |  | Other |  |
| Referral Source organisation: |  | | | | | |
| Referrer Name: |  | | | | | |
| Referrer contact Phone: |  | | | | | |
| Referrer contact Email: |  | | | | | |

**BATIAS Parental Advocacy Service Agreement**

|  |  |
| --- | --- |
| **Name of professional making request and role:** |  |
| **Team/department:** |  |
| **Email address:** |  |
| **Phone numbers:** |  |
| **Are you authorised to make this request?** |  |
| **If you are not authorised, please include name and contact details of person authorising this request:** |  |
| **Organisation requesting service:** | BATIAS Independent Advocacy Service |
| **Details of service requested:** | Parental Advocacy, Thurrock Childrens Social Care |
| **Name and contact details for Parents:** |  |
| **Please sign to agree that all parties will send relevant documents to advocate and parent five working days prior to meetings to be able to consult and respond prior to any meetings, as per GDPR safeguarding rules.** |  |
| **Date:** |  |

**For BATIAS office use:**

**Date request received: ………………………………………………………**

**BATIAS staff member responsible: ……………………………………………**