Initial Enquiry Form – Advocacy Support for Parents (Learning Disability/Autism)

Date.....
Name of person being referred.....
Date of Birth.....
Address.....
Post Code.....
Tel no.....
Ethnic origin.....
Gender.....
L.D. formal diagnosis YES/NO Autism formal diagnosis YES/NO
Preferred language.....
Communication issues.....
Access requirements.....
Potential risk to staff/any known incidents of physical or verbal abuse/threats
.....
Name of referrer.....
Job title.....
Organisation.....
Contact no.....
To assist us with prioritisation of cases please provide as much information as possible regarding the current situation of the family/children and the reason for the referral:.....
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.....
Pregnant YES/NO EDD.....
No. of children: .....
Accommodated YES/NO Sect. 20 I.C.O.
Date of next CIC review: .....
Issued Proceedings YES/NO Date of next court hearing.....
C.P. Plan YES/NO Date of next CPRC.....
C.I.N. Plan YES/NO Date of next C.I.N. meeting.....
Social Worker (Children).....Contact no.....
Social Worker (Adult).....Contact no.....
Solicitor.....Contact no.....
Referral Accepted – Waiting List
Allocated to: .....(Advocate)
Referral Declined - Reason.....
Re-directed YES/NO Agency.....