

**SAtA Circles Referral Form 2023-24**

**Please make sure you can answer yes to all 3 questions in Section 1**

For queries or support completing this form please contact us on: **0121 706 4696**

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| **Section 1 – Is your client eligible?** |

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| Does this person live in Solihull or is registered with a Solihull GP? | Yes [ ]  No [ ]  |
| Is this a person with Learning Disabilities and/or Autism? | Yes [ ] No [ ]  |
| Is this person aged over 18? | Yes [ ] No [ ]  |
| **If the answer to ALL the above questions is YES – please continue and complete Sections 2, 3 and 4**If any answer is NO, unfortunately your client is not eligible for this service. |
| **Section 2 – About the person** |

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| First Name(s): Click or tap here to enter text. | Surname: Click or tap here to enter text. |
| Preferred Name (if relevant): Click or tap here to enter text. |
| Home Address:Click or tap here to enter text. | Date of Birth: Click or tap here to enter text. |
| Telephone: Click or tap here to enter text. |
| Mobile: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |
| Postcode: Click or tap here to enter text. | Preferred method of contact: Click or tap here to enter text. |
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| **Section 3– About the referrer** |

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| Referrer Name: Click or tap here to enter text. | Capacity in which you know this person:Click or tap here to enter text.  |
| Telephone: Click or tap here to enter text. |
| Mobile: Click or tap here to enter text. |
| Email: Click or tap here to enter text. |

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| **Section 4 – About the referral** |

Please answer the following questions in as much detail as you can to enable us to assess which applications will benefit most from this service.

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| **What is the LDD/Autism Diagnosis the person been given? Please provide as much information as possible about the learning disability from either a GP/Other Professional working with the person.** |
| Click or tap here to enter text. |

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| **Is the person able to use public transport? If not, please tell us how they access services and the community at the moment e.g. taxi** |
| Click or tap here to enter text. |

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| **In what way is this person socially isolated?** |
| Click or tap here to enter text. |

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| **How does this person choose to communicate?** |
| Click or tap here to enter text. |
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| **What would a typical day look like for this person?** |
| Click or tap here to enter text. |

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| **What existing relationships does this person have in their life?** |
| Click or tap here to enter text. |

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| **What difference do you hope a Circle of Support would make?** |
| Click or tap here to enter text. |

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| **Is there anything else you think we should know when considering this referral?** |
| Click or tap here to enter text. |

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| **Has this referral been discussed with the person?** |
| Click or tap here to enter text. |

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| **What happens next?**  |
| When complete, please email the form to **office@solihulladvocacy.org.uk****. Please mark the subject header line ‘Circles Referral and the referring organisation’s name’** We will contact you for more information if required and then the application will be considered by a panel.  The panel meet every 3 months. After the panel, we will then let you know whether the application is suitable for the project or not and if so whether it has been successful for the forthcoming round or will be considered again for the following quarter.Any questions, please email nicky@solihulladvocacy.org.uk or call Nicky on 07808 627264 |