

Parent Peer Advocacy and Support Service

* Referral Form -

PPASS is a new service provided by Mental Health Matters Wales by highly qualified and experienced advocates and support workers with lived experience. This service is for adults involved in child protection proceedings

Please circle

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| **Self-Referral** (Please Select ) | **Yes**  | **No**  |
| **Third Party Referral** (Please Select) | **Yes**  | **No**  |
| **Consent given for referral to be made** (If No we will not be able to accept the referral. | **Yes**  | **No** |

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| **Clients Details**  |  |
| Title:  |  |
| First Name:  |  |
| Last Name: |  |
| Preferred pronoun i.e. She/He/They  |  |
| Date of birth (DD/MM/YYYY) |  |
| Please state if you have any Communication requirements:  |  |
| **Home Address:**  |  |
| Town  |  |
| County  |  |
| Postcode  |  |
| Mobile Number  |  |
| Landline number  |  |
| Email  |  |
| Preferred Method of Communicating e.g. Mobile Email Post  |  |
| Is there a preferred time/day for us to contact you ? |  |

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| **Third Party Referrers Details**  |  |
| Name of Organisation or Agency. |  |
| Referrers name |  |
| Relationship to client |  |
| **Address**  |  |
| Town  |  |
| County  |  |
| Postcode |  |
| Email Adress  |  |
| Mobile number  |  |
| Landline number  |  |

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| **Reason for referral**  | **Please tick**  |
| New/Existing families subject to CP enquiry/conferencing  |  |
| Parents of children who are looked after and seeking reunification  |  |
| Parents separated from their children by virtue of Special Guardianship Order  |  |
| **Please give details of support required**  |  |
| **Please detail any risk issues or incidents relevant to the person we should be aware of i.e. safeguarding concerns.** |  |
| **Please detail any information which you feel may be relevant to the PPASS service**  |  |

