# ICAA Referral Form

Referral Form for Independent Care Act Advocacy

**Advocacy and the duty to involve**
Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

**When does the advocacy duty apply?**
The advocacy duty will apply from the point of first contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding review. If it appears to the authority that a person or their carer has care and support needs, then a judgement must be made as to whether that person has substantial difficulty in being involved. If they do, and there is not an appropriate individual to support them, an independent advocate must be appointed to support and represent the person for the purpose of assisting their full involvement.

## 0 Office Use Only

**Case reference**

**Date referral received**

**Advocacy service referred to**

**Advocate/Team**

## 1 Referrer Details

**Date of referral**

**Organisation** (if referring on a professional basis)

**First Name**

**Last Name**

**Address**

**Postcode**

**Telephone Number**

**Email Address**

**Mobile Number**

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## 2 Referrer Details

**Job Title/Relationship to Client**

| | | | | | |
|---|---|---|---|---|---|
| Doctor | ☐ | Psychiatrist | ☐ | Ward Manager | ☐ |
| Care Manager | ☐ | Care Home Manager | ☐ | Team Manager (Health) | ☐ |
| Team Manager (Social) | ☐ | Social Worker (Hospital) | ☐ | Social Worker (Community) | ☐ |
| Nurse (Health Professional) | ☐ | Administrator | ☐ | | |

Other (please specify)

## 3 Client Details

**Title**

**Date of Birth**

**First Name**

**Last Name**

**Permanent Address**

**Postcode**

**Telephone Number**

**Email Address**

**Mobile Number**

**Current Address** (if different from above)

**Postcode**

**Telephone Number**

**Preferred method of contact**

| | | | | | |
|---|---|---|---|---|---|
| Any | ☐ | Phone | ☐ | Mobile | ☐ |
| SMS (Text) | ☐ | Email | ☐ | Post | ☐ |
| No Direct Contact | ☐ | | | | |

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## 3 Client Details cont.

### Location Setting

| | | | | | |
|---|---|---|---|---|---|
| Own home | ☐ | Own home (with support) | ☐ | Supported Living | ☐ |
| Hospital | ☐ | Care/Nursing Home | ☐ | Dementia Ward | ☐ |
| Acute Psychiatric Ward | ☐ | Forensic Secure Unit | ☐ | Prison | ☐ |
| Homeless | ☐ | No fixed abode | ☐ | | |

Other/Ward Name (if in hospital)

### Is English Spoken?

Yes ☐ No ☐ Not known ☐

### Primary Communication Method

| | | | |
|---|---|---|---|
| Spoken English | ☐ | Other spoken language (specify below) | ☐ |
| Words/Pictures/Makaton | ☐ | Gestures/Expressions/Vocalisations | ☐ |
| British Sign Language (BSL) | ☐ | No Obvious Means | ☐ |
| Not known | ☐ | | |

Other (please specify other spoken languages here)

### Does the client identify as having a disability?

Yes ☐ No ☐ Not known ☐ Prefers not to say ☐

### Does the client have a diagnosed or recognised disability? (select all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Mental Health Condition | ☐ | Acquired Brain Injury | ☐ | Serious Physical Illness | ☐ |
| Physical Disability | ☐ | Learning Disability | ☐ | Cognitive Impairment | ☐ |
| Sensory (Visual) | ☐ | Sensory (Auditory) | ☐ | Dementia/Alzheimer's | ☐ |
| Asperger's/Autistic Spectrum Condition | | | ☐ | Unconsciousness | ☐ |

Other (please specify)

### Military Connection

| | | | | | |
|---|---|---|---|---|---|
| Serving | ☐ | Veteran | ☐ | Carer relationship | ☐ |
| No | ☐ | Not known | ☐ | Prefers not to say | ☐ |

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the advocacy people

## 3 Client Details cont.

**Is there one disability which is most relevant to the case?** (If there is not, leave blank)

| | | |
|---|---|---|
| Mental Health Condition ☐ | Acquired Brain Injury ☐ | Serious Physical Illness ☐ |
| Physical Disability ☐ | Learning Disability ☐ | Cognitive Impairment ☐ |
| Sensory (Visual) ☐ | Sensory (Auditory) ☐ | Dementia/Alzheimer's ☐ |
| Asperger's/Autistic Spectrum Condition ☐ | | Unconsciousness ☐ |

**Gender**

| | | |
|---|---|---|
| Male ☐ | Female ☐ | Trans (Male to Female) ☐ |
| Trans (Female to Male) ☐ | Not known ☐ | Prefers not to say ☐ |

Other (please specify)

**Marital/Civil Partnership Status**

| | | |
|---|---|---|
| Single ☐ | Co-habiting ☐ | Married ☐ |
| Civil Partnership ☐ | Divorced/Dissolved ☐ | Separated ☐ |
| Widowed ☐ | Surviving (Civil Partnership) ☐ | Not known ☐ |
| Prefers not to say ☐ | | |

**Sexual Orientation**

| | | |
|---|---|---|
| Lesbian ☐ | Gay Man ☐ | Heterosexual ☐ |
| Bisexual ☐ | Questioning ☐ | Not known ☐ |
| Prefers not to say ☐ | | |

Other (please specify)

**Belief**

| | | |
|---|---|---|
| Buddhist ☐ | Christian ☐ | Hindu ☐ |
| Jewish ☐ | Muslim ☐ | Sikh ☐ |
| No Religion ☐ | Not known ☐ | Prefers not to say ☐ |

Other (please specify)

# ICAA Referral Form

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## 3 Client Details cont.

### Ethnicity

**Asian/Asian British**

Indian ☐ Pakistani ☐
Chinese ☐ Bangladeshi ☐
Other (please specify)

**Black/Black British**

African ☐
Caribbean ☐
Other (please specify)

**White**

British ☐
Irish ☐
Gypsy/Traveller ☐
Other (please specify)

**Mixed**

White & Black Caribbean ☐
White & Black African ☐
White & Asian ☐
Other (please specify)

**Other**

Arab ☐
Other (please specify)

Not known ☐
Prefers not to say ☐

**Does the client identify as Cornish?**

Yes ☐ No ☐ Not known ☐

## 4 Case Details

**Local Authority** (Council of referrer's location)

**Referral reason**

Adult needs assessment ☐
Preparation of care and/or support plan ☐
Review of carer's support plan ☐
Young carer assessment ☐
Safeguarding enquiry ☐

Carer's assessment ☐
Review of care & support plan ☐
Child needs assessment (transition) ☐
Child's carer's assessment (transition) ☐
Adult's safeguarding review ☐

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## 4 Case Details cont.

**Information about the client's current circumstances and need for advocacy support**

**Statutory referral eligibility**

Only paid professional support available ☐
No friend/family available ☐
Family/friend have vested interest ☐
No preferred friend/family available ☐
The Appropriate Person is in conflict/dispute with the Local Authority ☐

Other (please specify)

**Does the client have substantial difficulty in:** (select all that apply)

Understanding relevant information ☐
Retaining information ☐
Using or weighing up information ☐
Communicating (views, wishes and feelings) ☐

**Are you satisfied that this referral meets the criteria under the Care Act?** (and is in the best interests of the client if they have not been made aware or not given their consent)

Yes ☐ No ☐

**Is the client aware of this referral?**

Yes ☐ No ☐

**Has the client consented to this referral?**

Yes ☐ No ☐

**Is the client subject to Mental Health Act section 117 Aftercare?**

Yes ☐ No ☐ Not known ☐

**Has an Independent Mental Capacity Advocate (IMCA) been previously involved?**

Yes ☐ No ☐ Not known ☐

**Enter dates, times and venues of any important meetings or other deadlines**

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## 4 Case Details cont.

**Enter the name, relationship and contact details of others to be involved or consulted**

**If you are aware of any records of the person's wishes, give details**

**If there are any risks we should be aware of, give details** (otherwise state 'no known risks')

**Emergency contact information**

Name

Relationship to client

Phone

## 5 Declaration

In making this referral, I declare that:

- I declare that I wish to instruct an Independent Care Act Advocate.
- I am providing this information and making this referral in relation to the Care Act 2014.
- In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
- I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

Please email the completed form to: **info@theadvocacypeople.org.uk**
or post to: **P.O. Box 375, Hastings, TN34 9HU**

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If you have not received confirmation of this referral within **2 working days**, or you would like to discuss any aspects of a referral, please call **0330 440 9000**.

By requesting advocacy support, you give consent to **The Advocacy People** sharing information, as required for the purposes of providing the service.
For more information on our Privacy Notice, please ask your advocate or go to www.theadvocacypeople.org.uk/privacy

**Confidentiality**
Communications between you and **The Advocacy People** are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by **The Advocacy People** in accordance with current Data Protection legislation.

**The Advocacy People**