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.

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
Care Manager
Team Manager (Social)
Nurse (Health Professional)
Other (please specify)

Psychiatrist
Care Home Manager
Social Worker (Hospital)
Administrator

Ward Manager Team Manager (Health) Social Worker (Community)

3 Client Details

Title

First Name

Last Name

Permanent Address

Postcode

Telephone Number

Date of Birth

Email Address Mobile Number

Current Address (if different from above) Postcode

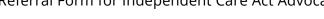
Telephone Number

Preferred method of contact

Any Phone Mobile SMS (Text) Email Post

No Direct Contact

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Client Details cont.

Location Setting

Own home Hospital Acute Psychiatric Ward

Homeless

Other/Ward Name (if in hospital)

Own home (with support) Care/Nursing Home Forensic Secure Unit

No fixed abode

Supported Living Dementia Ward

Prison

Is English Spoken?

Yes No Not known

Primary Communication Method

Spoken English Words/Pictures/Makaton British Sign Language (BSL)

Not known

Other (please specify other spoken languages here)

Other spoken language (specify below) Gestures/Expressions/Vocalisations

No Obvious Means

Does the client identify as having a disability?

Not known Yes No Prefers not to say

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

Mental Health Condition Acquired Brain Injury Physical Disability **Learning Disability** Sensory (Visual) Sensory (Auditory) Asperger's/Autistic Spectrum Condition

Other (please specify)

Serious Physical Illness Cognitive Impairment Dementia/Alzheimer's **Unconsciousness**

Military Connection

Serving Veteran Carer relationship Not known Prefers not to say No

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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

MaleFemaleTrans (Male to Female)Trans (Female to Male)Not knownPrefers 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)

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Ethnicity

Asian/Asian British

Indian Pakistani Chinese Bangladeshi

Other (please specify)

White

British Irish

Gypsy/Traveller
Other (please specify)

Other

Arab

Other (please specify)

Black/Black British

African Caribbean

Other (please specify)

Mixed

White & Black Caribbean White & Black African

White & Asian

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 Using or weighing up information

Retaining 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? Has the client consented to this referral?

Yes No Yes No

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

Not known Yes No

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

Not known No Yes

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

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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: or post to:

info@theadvocacypeople.org.uk 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