

**Care Act**

**Referral Form**

**Tel: 0345 310 1812**

**Email: referrals@advocacyforall.org.uk**

**Web: www.advocacyforall.org.uk**

**Advocacy for All**

**The Civic Centre**

**St Mary’s Road**

**Swanley**

**BR8 7BU**

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| **If you cannot complete this form, then please click view then edit.**  **Once completed please email to:** [**referrals@advocacyforall.org.uk**](mailto:referrals@advocacyforall.org.uk?subject=Care%20Act%20Advocacy%20Referral) | | | | |
| **BEFORE COMPLETING THIS FORM PLEASE CONFIRM THAT THE FOLLOWING CRITERIA HAS BEEN MET:** | | | | |
| Does the person being referred have substantial difficulty in being involved? | Yes |  | No |  |
| Does the person being referred have anyone appropriate to facilitate their involvement? | Yes |  | No |  |
| **COMPLETING THE FORM:**   * Type your answers onto the shaded areas which expand as you type. * In each section choose one answer only, unless stated otherwise. * More details can be entered under **any other relevant information.** | | | | |
| **Following receipt of referral, first contact with the referred person will be made within 3 working days of the referral.**  Advocacy for All is totally independent from statutory organisations and all other service delivery and is free from conflict of interest. | | | | |

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| **Referrer’s Name:** Click or tap here to enter text.  Relationship to client: Click or tap here to enter text.  Job title: Click or tap here to enter text.  Organisation: Click or tap here to enter text.  Address: Click or tap here to enter text.  Postcode: Click or tap here to enter text.  Tel: Click or tap here to enter text. Mobile: Click or tap here to enter text.  Email: Click or tap here to enter text.  Funding Authority: Click or tap here to enter text. | **Client Title:** Click or tap here to enter text.  Client name: Click or tap here to enter text.  P number: Click or tap here to enter text.  Date of birth: Click or tap here to enter text.  Man  Woman  Transgender  Non Binary  Intersex  Prefer not to say  Your own term:…………………..  Address of clients **current** location : Click or tap here to enter text.  Postcode: Click or tap here to enter text.  Tel: Click or tap here to enter text.  **Please specify location type**: Own Home  Residential Home  Nursing Home  Supported Living  Other  Click or tap here to enter text.  Is this a first referral? YES  NO |

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| **Nature of person’s impairment:** | |
| Choose an item.  Secondary Issue:  Choose an item.  If other, please specify: Click or tap here to enter text. |  |
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| **Primary means of communication:**  English  Other spoken language  British sign language  Words/pictures/Makaton  Gestures/facial expressions/vocalisations | **Ethnicity:** Choose an item. Other– please specify: Click or tap here to enter text. |
| **Religion:** Choose an item.  Other– please specify: Click or tap here to enter text. |
| **Sexuality:** Choose an item.  Other– please specify: Click or tap here to enter text. |

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| **Date of referral:** Click or tap here to enter text. **Date of proposed action:** Click or tap here to enter text. | |
| **Independent Advocates under the Care Act can support and represent a person in the following areas. Please tick the area(s) that the referred person needs support with:** | |
|  | A needs assessment |
|  | The preparation of a care and support plan |
|  | The review of a care and support plan |
|  | A carer’s assessment |
|  | The preparation of a carer’s support plan |
|  | The review of a carer’s support plan |
|  | A child’s transition to adult services assessment |
|  | Safeguarding Enquiry |
|  | Safeguarding Review |

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| **If the referral is in relation to Safeguarding, please state whether the person referred is:** |
| Choose an item. |
| Please state details: Click or tap here to enter text. |
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| Please state whether there are any planned meetings taking place and/or any other relevant information:  Click or tap here to enter text. |
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| Does the Advocate need to be aware of any risks (including behavioural issues), environmental hazards or infections when dealing with the case? | Yes |  | No |  |
| If yes, please provide details: | | | | |
| Click or tap here to enter text. | | | | |

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| **The referrer’s agreement:**  I confirm that I have consent from the person being referred to make a referral to Independent Advocacy. If the person being referred is not able to give consent, I confirm that I am satisfied that it is in the person’s best interests to be supported and represented by an Independent Advocate.  I understand that the information I provide about the person will be stored securely on a computer.  I understand that the advocate may request further information and/or records of the person’s assessment for substantial difficulty.. |

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| **Advocacy for All is an independent advocacy organisation** | **Charity no 1064855 Company no 3407428** |

