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|  **Referral Form – Advocacy for All** |
| **Please read the separate Guidance and then fill in the relevant sections and as much of form as possible. The more information you give us, the quicker we can process the referral and avoid delays. This form should be used to make referrals to one of the following advocacy services at Advocacy for All (AFA). Fill in parts 1 and sign part 3 plus:** |
| **Independent Mental Capacity Advocacy (IMCA) – fill in Part 2, Section H** |[ ]
| **Independent Care Act Advocacy (ICAA) – fill in Part 2, Section J** |[ ]

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| **Office use only:** | **Date referral received** |   | **Self-referral taken by**  |   |
| **Part 1** |
| **Section A** | **Type of referral** |
| If on behalf of someone do they know this referral is being made? | Yes |[ ]  Do they consent to the referral? | Yes |[ ]  May we contact them directly? | Yes |[ ]
|  | No |[ ]   | No |[ ]   | No |[ ]
| Does the person agree to AFA being given copies of relevant documents? | Yes |[ ]  No |[ ]
| **Capacity** |
| If the person lacks capacity to accept/decline advocacy support, please confirm that you are referring in their best interests (it would be good practice to inform the person of the referral where possible) | Yes |[ ]
|  | No |[ ]
| Has the person been assessed as lacking capacity to make decisions about the issue/s | **Yes** |[ ]  **No** |[ ]
| Date capacity assessment carried out |   | Confirm copy of assessment is attached to the referral |[ ]
| **Section B** | **Details of person needing advocacy** |
| First name/s |   | Last name |   |
| Name known as (if different) | Click here to enter text. | Date of birth |   |
| Current address |   |
|  | Postcode |   |
| Telephone number |   | Mobile number |   |
| Email  |   |
| Other address (if relevant): |   |
|  | Postcode |   |
| Preferred language/s |   | Is an interpreter required? | [ ]  |
| Communication needs  |   |
| **Section C** | **Person making the referral** (if the referral is on behalf of someone else) |
| First name/s |   | Last name |   |
| Job title (if any) | Click here to enter text. |
| Organisation (if any) | Click here to enter text. |
|  |  |
| Address | Click here to enter text. |
|  | Postcode | Click here to enter text. |
| Telephone number | Click here to enter text. | Mobile number | Click here to enter text. |
| Email  | Click here to enter text. |
| Relationship to person being referred  | Click here to enter text. |
| Where did you hear about Advocacy for All | Click here to enter text. |
| **Section D** | **Reason for referral** *(brief summary)* |
| Click here to enter text. |
| Are there any urgent meetings planned? (give details): | **Yes** |[ ]  **No** |[ ]
| Click here to enter text. |
| Are there any safeguarding issues? (give details): | **Yes** |[ ]  **No** |[ ]
| Click here to enter text. |
| **Section E** | **Key people involved** |
| **GP**  | First name | Click here to enter text. | Last name |   |
| Surgery |   |
| Surgery address  | Click here to enter text. |
|  | Postcode | Click here to enter text. |
| Telephone number | Click here to enter text. | Email | Click here to enter text. |
| **Consultant** (if any) | First name | Click here to enter text. | Last name | Click here to enter text. |
| Consultant address  | Click here to enter text. |
|  | Postcode | Click here to enter text. |
| Telephone number | Click here to enter text. | Email | Click here to enter text. |
| **Social worker or Care Manager/ Coordinator** | First name | Click here to enter text. | Last name |   |
| Team |   |
| Social Worker/Care Coordinator address  |   |
|  | Postcode | Click here to enter text. |
| Telephone number |   | Email |   |
| **Name of Responsible Clinician** |   |
| **Name of Nearest Relative** |   |
| **Other key people involved** (if any) |   |
| **Section F** | **Risk information (Referral cannot be processed without risk information)** |
| No known risk |[ ]  Risk has been identified |[ ]  Confirm risk assessment is attached (e.g. FACE) |[ ]
| **If risk has been identified, provide details, including anything we should know to make sure the person and the Advocate remain safe.** |
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| **Section G** | **Profile of person needing advocacy** |
| **Diversity is important to us. We collate information to help us shape our services to represent the needs of our communities and to fight for a fairer society. You can help by giving us the following information about how you describe yourself. If you are referring someone, please discuss how they describe themselves and complete. We will keep this information confidential and will only use it anonymously.** |
| **Gender: Which option best describes how you think about yourself?**  |
| Female |[ ]  Male |[ ]  Prefer not to say |[ ]  In another way (describe): |[ ]   |
| **Disability** *(cross all boxes that apply)* |
| **Do you consider yourself to have a disability which has a substantial and long-term (has lasted or is expected to last at least 1 year) adverse effect on your ability to carry out normal day-to-day activities? (Disability Discrimination Act definition)** | Yes |[ ]
|  | No |[ ]
|  | Prefer not to say |[ ]
| **If yes please tell us about the nature of your disability (cross all boxes that apply and describe)** |
| Mental health needs |[ ]  Physical disability |[ ]  Learning disability |[ ]
| Neurological condition |[ ]  Autistic spectrum |[ ]  Other |[ ]
| **Please describe** |
|   |
| **Sexuality: Which option best describes how you think of yourself** (*cross one box)* |
| Heterosexual/straight |[ ]  Bisexual |[ ]  Lesbian |[ ]  Gay man |[ ]  Prefer not to say |[ ]
| In another way (please describe): |[ ]    |
| **Ethnic origin: Which option best describes your ethnic group or background** *(cross one box)***.** Categories based on Census 2011 categories. |
| **Asian** British/Bangladeshi |[ ]  **White** British |[ ]
| **Asian** British/Indian |[ ]  **White** Irish |[ ]
| **Asian** British/Pakistani |[ ]  **White** Gypsy/Traveller |[ ]
| **Asian** British/Chinese |[ ]  Any other **White** background (describe below): |[ ]
| Any **other** **Asian** background (describe below): |[ ]  **Mixed** Asian and White |[ ]
| **Black** British/Black African |[ ]  **Mixed** Black African and White |[ ]
| **Black** British/Black Caribbean |[ ]  **Mixed** Black Caribbean and White |[ ]
| Any **other Black/African/Caribbean** background (describe below) |[ ]  Any **other Mixed/multiple ethnic** background (describe below): |[ ]
| Any **other** **Ethnic group** (describe below):  |[ ]  Prefer not to say/Not known/Not given |[ ]
| **Please describe** |
|   |
| **Religion/belief: Which group do you most identify with?** *(cross one box)* |
| Buddhist |[ ]  Christian |[ ]  Hindu |[ ]  Jewish |[ ]  Muslim |[ ]  Sikh |[ ]
| No religion |[ ]  Prefer not to say |[ ]  In another way (describe): |[ ]    |

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| **Part 2: Which advocacy service are you referring to** |
| **Section H** | **Independent Mental Capacity Advocacy (IMCA)**  |
| **The decision to be made in this case relates to** *(please cross box that applies)*:  |
| **Serious medical treatment** | **Yes** |[ ]
| **Change of accommodation**:NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and* the person will stay in hospital for 28 days or more
* the person will stay in accommodation for 8 weeks or more
 | **Yes** |[ ]
| **Care Review** in relation to accommodation where the person would benefit from an IMCA | **Yes** |[ ]
| **Safeguarding Adults proceedings** for an alleged perpetrator who lacks capacity (the person may have family and still be eligible for IMCA in this instance) | **Yes** |[ ]
| **Please provide a brief summary:** |
|   |
| **Decision Maker’s confirmation (AFA cannot accept an IMCA referral until we have received the following)** |
| I confirm that I am the Decision Maker for this issue |[ ]  Are you also the Referrer |[ ]
| I confirm that I deem this person to be un-befriended, with no-one appropriate to consult regarding this decision (unless this is a safeguarding issue) |[ ]
| I confirm the person being referred has been deemed to lack capacity to make **this decision** |[ ]
| I confirm that a capacity assessment for this decision was done |[ ]  Date |   | Copy attached |[ ]
| **Decision Maker’s details (if the Decision-Maker is also the referrer, please do not fill in these details)** |
| First name/s |   | Last name | Click here to enter text. |
| Job title | Click here to enter text. |
| Department/Team | Click here to enter text. |
| Address | Click here to enter text. |
|  | Postcode | Click here to enter text. |
| Telephone number | Click here to enter text. | Mobile number | Click here to enter text. |
| Email  | Click here to enter text. | Fax number |   |
| **Section J** | **Independent Care Act Advocacy (ICAA)**  |
| Does the person have ‘substantial difficulty’ being involved | **Yes** |[ ]  **No** |[ ]
| Is there an ‘Appropriate Individual’ who can support the person’s involvement in the process (such as an existing advocate or unpaid family member or friend) | **Yes** |[ ]  **No** |[ ]
| **Issue that independent advocacy is required for** *(we can only accept referrals for adults for the issues below)*:  |
| Needs assessment | **Yes** |[ ]
| Carer’s assessment | **Yes** |[ ]
| Preparation of a support plan or care and support plan | **Yes** |[ ]
| Review of a support plan or care and support plan | **Yes** |[ ]
| Safeguarding enquiry | **Yes** |[ ]
| Safeguarding review | **Yes** |[ ]
| **Any additional information:** |
| Click here to enter text. |

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| **Part 3: Signatures** |
| **Because of the Data Protection Act a signature is needed to say that you agree to Advocacy for All securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of Advocacy for All that all personal data will be held in accordance with the principles and requirements of Data Protection and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. AFA is a confidential service.**  |
| **Referrer** |
| I agree that AFA can securely hold the client’s personal information as detailed above. I am providing this information with the client’s consent or in their best interests. |
| Name |   |
| Signature (not required if emailing) |   | Date |   |
| **Client/patient** |
| I agree that AFA can securely hold my personal information as detailed above.  |
| Name |   |
| Signature (not required if emailing) |   | Date |   |
| **Please check that you have completed all necessary parts of the form and attached ALL necessary information before returning the form to AFA. Emailed referrals are preferred as they can be processed quickly and without use of paper. Referrals are safe to send to this email address as it is encrypted**  |
| **Advocacy for All**Civic CentreSt Mary’s RoadSwanleyBR8 7BU | Email: referrals@advocacyforall.org.ukTelephone: 0345 310 1812Website: [www.advocacyforall.org.uk](http://www.advocacyforall.org.uk) |
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