St Helens Advocacy Hub

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CONFIDENTIAL

First Name:		Surname:	
Date of Birth:			
Home Address & Postcode:			
Current location if different from above **(including telephone and ward details)**			
Telephone Number:			
Mobile Number:			
Email Address:			
NHS Number:			
Funding Authority:			
Preferred method of contact:	Phone ☐ Email ☐ Post ☐		

Does this person have any communication needs?	
Please detail any known risks	

CONSENT - Advocacy Operates under the GDPR Guidelines

If the person being referred is deemed to lack capacity, please sign below to say that you are referring in the client's best interest

Does the person have capacity to consent to this referral?	☐ Yes ☐ No
If yes, has consent been obtained?	☐ Yes ☐ No
Signature of referrer:	

Gender:	☐ Male ☐ Female ☐ Prefer not to say ☐ Female, male at birth ☐ Male, female at birth ☐ Other, please specify ☐ Non-binary
Pronouns:	☐ He/him ☐ She/her ☐ They/them _____
Sexual Orientation:	☐ Asexual ☐ Bisexual ☐ Heterosexual ☐ Gay/Lesbian ☐ Prefer not to say ☐ Other, please specify _____
Disability:	☐ Acquired brain injury ☐ Multiple impairments ☐ Neurological conditions ☐ Carer ☐ Older person ☐ Physical disability ☐ Dementia ☐ Sensory impairment ☐ Stroke ☐ Long term health condition ☐ Substance misuse ☐ Other (please specify) ☐ Autism ☐ Learning disability ☐ Communication difficulties ☐ Mental health _____
Ethnic Origin:	☐ African ☐ Arab/British Arab ☐ Asian/British Asian ☐ Black/Black British ☐ Carribean ☐ Chinese ☐ European ☐ Gypsy/Roma ☐ Indian ☐ Mixed heritage ☐ Pakistani ☐ White British ☐ White Irish ☐ White other ☐ Prefer not to say ☐ Other, please specify: _____

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Religion:	☐ Atheist ☐ Catholic ☐ Christian ☐ Jewish	☐ Sikh ☐ Buddhist ☐ Hindu ☐ Muslim	☐ Jehovah Witness ☐ Not known ☐ No religion ☐ Other, please specify: _____

Marital Status:	☐ Married/Civil Partnership ☐ Separated ☐ Other, please specify: _____	☐ Single ☐ Living together	☐ Divorced ☐ Widowed

Please provide Referrer and Decision-Maker details

	Referrer	Decision Maker
Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

Advocacy Service Information

Please only complete information specific to the advocacy type you are referring for.

Care Act Advocacy - please complete all below sections for us to be able to triage the referral

Care Act Advocacy ☐		Care Act for Carers ☐	
Assessment ☐	Review ☐	Safeguarding ☐	Support Planning ☐
Will this person have substantial difficulty in being involved with the process?	Yes ☐	No ☐	
Has the client been deemed as having no appropriate person to facilitate the client's engagement in the process?	Yes ☐	No ☐	

Independent Mental Capacity Advocacy (IMCA) - please complete all below sections for us to be able to triage the referral

Serious Medical Treatment	Change in Accommodation	Safeguarding	Care Review
Has the client been assessed as lacking capacity around this issue?	Yes ☐	No ☐	
Has the client been deemed to not have appropriate friends or family who can be consulted?	Yes ☐	No ☐	
Date of capacity assessment:			
Who completed the capacity assessment?			
Any upcoming meeting dates?			

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Independent Mental Health Advocacy (IMHA) - please complete all below sections for us to be able to triage the referral

Section 2 ☐	Section 3 ☐	CTO ☐	Guardianship ☐	Other: _____
Section start date:				
Ward:				
Any upcoming meeting dates?				

Generic Advocacy

Is the issue regarding health or social care?	Yes ☐	No ☐
Is the issue relating to Social Care Complaint?	Yes ☐	No ☐

Health Complaints

Is the issue regarding NHS services?	Yes ☐	No ☐

REFERRAL REASONS (Please add any relevant information)

Please return this form to -
Email: **referral@sthelensadvocacyhub.org.uk**
Phone: **0300 3030 202**
Website: **www.sthelensadvocacyhub.org.uk**

St.Helens Council