

## CONFIDENTIAL

First Name:		Surname:	
Date of Birth:			
Home Address & Postcode:			
Current location if different from above ( <b>including telephone and ward details</b> )			
Telephone Number:			
Mobile Number:			
Email Address:			
NHS Number:			
Funding Authority:			
Preferred method of contact:	Phone	Email	Post
Does this person have any communication needs?			
<b>Please detail any known risks</b>			

## 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, has consent been obtained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of referrer:		

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

Religion:	<input type="checkbox"/> Atheist <input type="checkbox"/> Catholic <input type="checkbox"/> Christian <input type="checkbox"/> Jewish	<input type="checkbox"/> Sikh <input type="checkbox"/> Buddhist <input type="checkbox"/> Hindu <input type="checkbox"/> Muslim	<input type="checkbox"/> Jehovah Witness <input type="checkbox"/> Not known <input type="checkbox"/> No religion <input type="checkbox"/> Other, please specify: _____
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Marital Status:	<input type="checkbox"/> Married/Civil Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Other, please specify: _____	<input type="checkbox"/> Single <input type="checkbox"/> Living together	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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### 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?			

**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 <input type="checkbox"/>	No <input type="checkbox"/>
Is the issue relating to Social Care Complaint?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Health Complaints**

Is the issue regarding NHS services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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**REFERRAL REASONS** (Please add any relevant information)