



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, male at birth ☐ Non-binary	☐ Female ☐ Male, female at birth	☐ Prefer not to say ☐ Other, please specify _____
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 ☐ Carer ☐ Dementia ☐ Long term health condition ☐ Autism ☐ Communication difficulties ☐ Multiple impairments ☐ Older person ☐ Sensory impairment ☐ Substance misuse ☐ Learning disability ☐ Mental health ☐ Neurological conditions ☐ Physical disability ☐ Stroke ☐ Other (please specify) _____		
Ethnic Origin:	☐ African ☐ Black/Black British ☐ European ☐ Mixed heritage ☐ White Irish ☐ Other, please specify: _____ ☐ Arab/British Arab ☐ Carribean ☐ Gypsy/Roma ☐ Pakistani ☐ White other ☐ Asian/British Asian ☐ Chinese ☐ Indian ☐ White British ☐ Prefer not to say		



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

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

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?			

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

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

Is the issue regarding NHS services?	Yes ☐	No ☐
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REFERRAL REASONS (Please add any relevant information)



BLACKBURN
with
DARWEN
COUNCIL