

CONFIDENTIAL
ADULT REFERRAL FORM

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 Other _____		
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 Caribbean Gypsy/Roma Pakistani White other	Asian/British Asian Chinese Indian White British Prefer not to say

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?			

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)