

## CONFIDENTIAL

Client Name:	
Date of Birth:	
Home Address & Postcode:	
Funding Local Authority:	
Telephone number:	
Present location, postcode, tel. (if different from above) <b>If hospital please include ward number</b>	

## CONSENT - Advocacy Operates under the GDPR Guidelines

Has client consented to this referral?	
<b>For statutory:</b> if the client is <b>not able</b> to consent, are you giving us instruction? (IMHA, IMCA, CAA)	

Gender:		Ethnicity:	
Disability:			
Does this person have any communication needs?			

Please detail any <b>risks</b> that the client may pose to N-Compass Staff that we should be aware of:

## REFERRER DETAILS

## DECISION MAKER DETAILS

Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

## ADVOCACY SERVICE INFORMATION

Only complete information for the specific type of advocacy you are referring for. If you answer no to any questions in that section you will not meet the criteria but may still be eligible for generic advocacy.

**CARE ACT ADVOCACY**       **CARE ACT ADVOCACY 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 by the referrer as having no appropriate person to facilitate the clients engagement in the process ?       Yes     No

**INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA)**

Serious Medical Treatment     Change in Accommodation     Safeguarding     Care Review

Has this client been deemed to not have appropriate friends or family who can be consulted?       Yes     No

Has this person been assessed as lacking capacity around this issue?       Yes     No

Date the capacity assessment was undertaken? \_\_\_\_\_

Who completed the capacity assessment? \_\_\_\_\_

**INDEPENDENT MENTAL HEALTH ADVOCACY (IMHA)**

Section 2     Section 3     Community Treatment Order     Other \_\_\_\_\_

What ward are they currently on? \_\_\_\_\_

When did the section begin? \_\_\_\_\_

**GENERIC ADVOCACY**

Is the issue regarding health or social care?       Yes     No

Is this person an informal patient on a psychiatric ward?       Yes     No

**REFERRAL REASON** (Please add any Relevant information inc. meeting dates)

Please return this form to -

Email: [referral@buryadvocacyhub.co.uk](mailto:referral@buryadvocacyhub.co.uk) Phone: 0300 3030 206

Post: n-compass Advocacy, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF

[www.buryadvocacyhub.co.uk](http://www.buryadvocacyhub.co.uk)