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|  **Referral Form – Advocacy for All** |
| **Please read the separate Guidance and then fill in the relevant sections and as much of form as possible. The more information you give us, the quicker we can process the referral and avoid delays.** **This form should be used to make referrals to one of the following advocacy services at Advocacy for All (AFA).** **Please indicate below which service you are requesting.** |
| **Independent Mental Capacity Advocacy (IMCA) – fill in part 1, part 2 section H and sign part 3.** |[ ]
| **Independent Care Act Advocacy (ICAA) – fill in part 1, part 2 section J and sign part 3.** |[ ]

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| **Part 1** |
| **Section A** | **Consent and Capacity** |
| If on behalf of someone do they know this referral is being made? | Yes |[ ]  Do they consent to the referral? | Yes |[ ]  May we contact them directly? | Yes |[ ]
|  | No |[ ]   | No |[ ]   | No |[ ]
| Does the person agree to AFA being given copies of relevant documents? | Yes |[ ]  No |[ ]
| **Capacity** |
| If the person lacks capacity to accept/decline advocacy support, please confirm that you are referring in their best interests (it would be good practice to inform the person of the referral where possible) | Yes |[ ]
|  | No |[ ]
| Does the client have an attorney, receiver or guardian?  | Yes |[ ]  No |[ ]
| Please give name and telephone number and clarify the issue that they are dealing with:   |
| **Section B** | **Details of person needing advocacy** |
| First name/s |   | Last name |   |
| Name known as (if different) |   |
| **Date of birth** |   | **Reference/P Number** |   |
| Address at time of referral |   |
|  | Postcode |   |
| Telephone number |   | Mobile number |   |
| Email  |   |
| Other address (if relevant): |   |
|  | Postcode |   |
| Please specify location type | Own Home [ ]  Residential Home [ ]  Nursing Home [ ]  Supported Living [ ]  Hospital [ ]  Other (please specify)  |
| Funding Authority |   |
| **Section C** | **Person making the referral**  |
| First name/s |   | Last name |   |
| Job title  |   |
| Organisation  |   |
| Address |   |
|  | Postcode |   |
| Telephone number |   | Mobile number |   |
| Email  |   |
| Relationship to person being referred  |   |
| Where did you hear about Advocacy for All |   |
| **Section D** | **Reason for referral** *(brief summary)* |
|   |
| Are there any urgent meetings planned? (give details): | **Yes** |[ ]  **No** |[ ]
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| Are there any safeguarding issues? (give details): | **Yes** |[ ]  **No** |[ ]
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| **Section E** | **Key people If relevant to referral** |
| **GP**  | First name |   | Last name |   |
| Surgery |   |
| Surgery address  |   |
|  | Postcode |   |
| Telephone number |   | Email |   |
| **Consultant** (if any) | First name |   | Last name |   |
| Consultant address  |   |
|  | Postcode |   |
| Telephone number |   | Email |   |
| **Social worker or Care Manager/ Coordinator** | First name |   | Last name |   |
| Team |   |
| Social Worker/Care Coordinator address  |   |
|  | Postcode |   |
| Telephone number |   | Email |   |
| **Name of Responsible Clinician** |   |
| **Name of Nearest Relative (if any)** |   |
| **Other key people involved** **(if any)** |   |
| **Section F** | **Risk information (Referral cannot be processed without risk information)** |
| No known risk |[ ]  Risk has been identified |[ ]  Confirm risk assessment is attached (e.g. FACE) |[ ]
| **If risk has been identified, provide details, including anything we should know to make sure the person and the Advocate remain safe.** |
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| **Section G** | **Equality and Diversity** |
| **Diversity is important to us. We collate information to help us shape our services to represent the needs of our communities and to fight for a fairer society. If you are referring someone, please discuss how they describe themselves and complete. We will keep this information confidential and will only use it anonymously.** |
| **Gender: Which option best describes how you think about yourself?**  |
| Woman |[ ]  Man |[ ]  Transgender | [ ]  | Non Binary | [ ]  |
| Intersex |[ ]  Prefer not to say |[ ]   |
| **Disability** *(cross all boxes that apply)* |
| **Do you consider yourself to have a disability which has a substantial and long-term (has lasted or is expected to last at least 1 year) adverse effect on your ability to carry out normal day-to-day activities? (Disability Discrimination Act definition)** | Yes |[ ]
|  | No |[ ]
|  |  |
| **If yes, please choose one:**Choose an item.**Secondary issue:**Choose an item.**If other please specify:** Click or tap here to enter text. |
| **Primary means of Communication**  |   |
| **Sexuality: Which option best describes how you think of yourself**  |
| **Choose one:**Choose an item. |
| **Other (please describe)** |   |
| **Ethnic origin: Which option best describes your ethnic group or background**  |
| **Choose one:**Choose an item. |
| **If other please specify** |   |
| **Religion/belief: Which group do you most identify with?** |
| **Choose one:**Choose an item. |
| **If other please specify** |   |

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| **Part 2: Which advocacy service are you referring to?** |
| **Section H** | **Independent Mental Capacity Advocacy (IMCA)**  |
| **The decision to be made in this case relates to** *(please cross box that applies)*:  |
| **\*Serious medical treatment,** please indicate below treatment being referred for. | **Yes** |[ ]
| **Change of accommodation**:NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and* the person will stay in hospital for 28 days or more
* the person will stay in accommodation for 8 weeks or more
 | **Yes** |[ ]
| **\*Care Review** in relation to accommodation. Please indicate below how long the client has resided at the current accommodation**.** | **Yes** |[ ]
| **\*Safeguarding Adults proceedings** If yes, please state whether the client referred is:**Please select one:** Choose an item.The person may have family and still be eligible for IMCA in this instance. \***Please indicate what the protective measures are in the box below.** | **Yes** |[ ]
| **\*Please provide a brief summary:** |
|   |
| **Decision Maker’s confirmation (AFA cannot accept an IMCA referral until we have received the following)** |
| I confirm that I am the Decision Maker for this issue |[ ]  Are you also the Referrer |[ ]
| I confirm that I deem this person to be un-befriended, with no-one appropriate to consult regarding this decision (unless this is a safeguarding issue) |[ ]
| I confirm the person being referred has been deemed to lack capacity to make **this decision.** |[ ]
| I confirm that a capacity assessment for this decision was done. |[ ]  Date |   | Copy attached |[ ]
| **Decision Maker’s details (if the Decision-Maker is also the referrer, please do not fill in these details)** |
| First name/s |   | Last name |   |
| Job title |   |
| Department/Team |   |
| Address |   |
|  | Postcode |   |
| Telephone number |   | Mobile number |   |
| Email  |   | Fax number |   |
| **Section J** | **Independent Care Act Advocacy (ICAA)**  |
| Does the person have ‘substantial difficulty’ being involved | **Yes** |[ ]  **No** |[ ]
| Is there an ‘Appropriate Individual’ who can support the person’s involvement in the process (such as an existing advocate or unpaid family member or friend) | **Yes** |[ ]  **No** |[ ]
| **Issue that independent advocacy is required for** *(we can only accept referrals for adults for the issues below)*:  |
| Needs assessment | **Yes** |[ ]
| Preparation of care and support plan | **Yes** |[ ]
| Review of care and support plan | **Yes** |[ ]
| Carer’s assessment | **Yes** |[ ]
| Preparation of carers care and support plan | **Yes** |[ ]
| Review of carers care and support plan | **Yes** |[ ]
| A child’s transition to adult services assessments | **Yes** |[ ]
| Safeguarding enquiry | **Yes** |[ ]
| Safeguarding review | **Yes** |[ ]
| **Any additional information:** |
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| **Part 3: Signatures** |
| **Because of the Data Protection Act a signature is needed to say that you agree to Advocacy for All securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of Advocacy for All that all personal data will be held in accordance with the principles and requirements of Data Protection and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. AFA is a confidential service.**  |
| **Referrer** |
| I agree that AFA can securely hold the client’s personal information as detailed above. I am providing this information with the client’s consent or in their best interests. |
| Name |   |
| Signature (not required if emailing) |   | Date |   |
| **Client/patient** |
| I agree that AFA can securely hold my personal information as detailed above.  |
| Name |   |
| Signature (not required if emailing) |   | Date |   |
| **Please check that you have completed all necessary parts of the form and attached ALL necessary information before returning the form to AFA. Emailed referrals are preferred as they can be processed quickly and without use of paper. Referrals are safe to send to this email address as it is encrypted**  |
| **Advocacy for All**Civic CentreSt Mary’s RoadSwanleyBR8 7BU | Email: referrals@advocacyforall.org.ukTelephone: 0345 310 1812Website: [www.advocacyforall.org.uk](http://www.advocacyforall.org.uk) |
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