**Referral Form (two pages)**

**Independent Health Complaints Advocacy Service**

SWAN supports Somerset residents to make a formal complaint to any NHS organisation in England, about the care of service they received. This includes all Health Services provided and/or funded by the NHS: GPs and surgeries, hospitals, pharmacies, opticians, dentists and other health care practitioners – but excludes private treatments.

|  |  |  |  |
| --- | --- | --- | --- |
| **Complainant information** | | | |
| **Mr/Mrs/Miss/Ms/Other** | **Date of birth** | | |
| **Full name:** | **Known as:** | | |
| **Gender: male/female/transgender** | | |
| **Address:**  **Postcode:** | **Telephone numbers:**  **1.**  **2.**  **Email:**  **May we leave a message? Yes/No** | | |
| **Do you have a disability? Please give brief details and circle as appropriate:** | **Learning Disability** | | **Physical Disability** |
| **Mental ill health** | | **Sensory Impairment** |
| **Ageing (over 60)** | | **Carer (for the patient or another adult/child)** |
| **Dementia** | |
| **How did you hear about Swan?:** | **Signposted to (if appropriate):** | | |
| **Name and contact number of referrer:** |
| **Patient information (if different from complainant)** | | | |
| **Mr/Mrs/Miss/Ms/Other** | **Full name:** | | |
| **Date of birth:** | **Patient deceased? (Please give date):** | | |
| **Known as:** | **Gender: male/female/transgender** | | |
| **Address**  **Postcode:** | **Contact telephone numbers (if appropriate):**  **1.**  **2.**  **Email:**  **May we leave a message? Yes/No** | | |
| **Does/did the patient have a disability? Please give brief details and circle as appropriate:** | **Learning Disability** | **Physical Disability** | |
| **Mental ill health** | **Sensory Impairment** | |
| **Dementia** | **Carer (for the complainant or another adult/child)** | |
| **Ageing (over 60)** | **Other/none** | |
| **Incident date:** | **Complaint against:** | | |
| **Trust (eg. Somerset Partnership NHS Foundation Trust)** | **Confidentiality discussed? (For office use only)** | | |
| **Are there any risks that we should be aware of when visiting or arranging to meet with the client** eg. Pets at the home, Substance/Tobacco use, Behavioural issues, Neighbourhood concerns, Risk of self harm/Suicide, other members of the household | | | |
| **Please detail any important deadlines or meeting dates** | | | |
| **Self Help Toolkit Offered?: Yes/No**  **Self Help Toolkit Accepted?: Yes/No If No, why not?** | | | |
| **Complaint summary: (please continue on additional sheet as necessary).** | | | |

**The information on this page is required for service monitoring purposes only**

**Please tick as appropriate**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Ethnic Origin** | | **Client’s Religion or Belief** | | | | **Language** | | | |
| White British |  | Bahi | | |  | What is your first language? | |  | |
| Any other white background |  | Buddhism | | |  |  | |  | |
| Black/African/Caribbean |  | Christianity | | |  |  | |  | |
| Mixed and Multiple ethnic groups |  | Hinduism | | |  |  | |  | |
| Asian |  | Humanism | | |  |  | |  | |
| Other ethnic Group |  | Islam | | |  |  | |  | |
| Prefer not to say |  | Judaism | | |  |  | |  | |
|  |  | Paganism | | |  |  | |  | |
|  |  | Sikhism | | |  |  | |  | |
|  |  | Other | | |  |  | |  | |
|  |  | Prefer not to say | | |  |  | |  | |
|  |  |  | | |  |  | |  | |
|  |  |  | | |  |  | |  | |
| **Gender** | | | | | | | | | |
| **Do you identify;-** |  | **Does your gender identity match completely the sex you were registered at birth?** | | **Sexual Orientation** | | | | |  |
| As a woman |  | Bisexual | | | | |  |
| As a man |  | Gay | | | | |  |
| In some other way |  | Yes |  | Heterosexual | | | | |  |
| Prefer not to say |  | No |  | Lesbian | | | | |  |
|  |  | Prefer not to say |  | Other | | | | |  |
|  |  |  |  | Prefer not to say | | | | |  |
|  |  |  | |  | | | | | |
|  |  |  | |  | | | | | |
| **Carers** | | | | | | | | | |
| Do you provide care for anyone (eg a parent, child, other relative, an elderly person, friend or neighbour) who has a form of disability (sensory loss, physical, learning disability, mental health problem) long or terminal illness? | | | | | | | Yes | |  |
| No | |  |
| Prefer not to say | |  |