**Continuing Healthcare (CHC) Advocacy Referral Form – Pan Dorset**

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| --- | --- |
| Are you asking for an advocate for yourself?[ ]  Yes [ ]  No | If yes, how did you hear of SWAN? |
| If you are asking for an advocate for someone else, have they given their consent? [ ]  Yes [ ]  No |
| May we contact the client directly?[ ]  Yes [ ]  No | If no, who should we contact? |
| **Referrer Information (if other than the client)** |
| Full Name:  | Job Title (if appropriate):  |
| Address: | Telephone No: Mobile No. |
| Email Address:  |
| Postcode:  | Relationship to Client:  |
| **Client Information (the client is the adult needing an advocate)** |
| Full Name:  | Date of Birth: DD/MM/YYYY |
| Location at point of referral (e.g. hospital): | Home address (if different): |
| Postcode:  | Postcode:  |
| Phone no. at point of referral:  | Home phone no: |
| Email address: |
| **Carer Information** **(the client’s unpaid carer or family member in need of support, if different from referrer)** |
| Full Name:  | Relationship to Client: |
| Address: | Telephone No:  |
| Email Address:  |
| Postcode:  |  |
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| --- |
| **Support Required For:** |
| CHC Checklist |[ ]
| Decision Support Tool assessment |[ ]
| CHC Review |[ ]
| Decision Appeal |[ ]

**If you are wishing to refer for other areas of advocacy, please complete the relevant form on** [**https://swanadvocacy.org.uk/refer/dorset/**](https://swanadvocacy.org.uk/refer/dorset/) |
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| --- | --- | --- | --- |
| **Continuing Healthcare Advocacy Referral Checklist** | Yes | No | N/A |
| Have reasons for this referral been discussed with the client? |[ ] [ ] [ ]
| Have reasons for this referral been discussed with the client’s carer or family? |[ ] [ ] [ ]
| Has the CHC Checklist been completed? |[ ] [ ] [ ]
| Has the Decision Support Tool (DST) been completed? |[ ] [ ] [ ]
| Is this a review of the current package of care in place? |[ ] [ ] [ ]

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| **Does the client have any additional needs we should consider when visiting, or arranging to meet with them?** (e.g. do they have difficulty in communicating verbally/in writing?) |
|  |
| **Are there any risks that we should be aware of when visiting or arranging to meet with the client?** |
|  |
| **Any other relevant information including the any planned meeting dates and the client’s desired outcome:** |
|  |
| **In making this referral, I declare that:** * **I wish to request advocacy support from South West Advocacy Network (SWAN).**
* **I understand that client information supplied on this form will be stored safely on SWAN’s system.**
* **I confirm that I am either a self-referring client or I have consent from the client to make the referral, or I have the authority to make the referral for the client.**

By requesting advocacy support, you give consent to SWAN sharing information where necessary for the purpose of providing this service. All data held by SWAN is held in accordance with the current UK General Data Protection Regulations legislation. |

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

**but is a compulsory section of this referral form**

Please tick as appropriate

|  |  |
| --- | --- |
| **Client’s Ethnic Origin** | **Client’s Religion or Belief** |
| White British |[ ]  Bahi |[ ]
| Any other white background |[ ]  Buddhism |[ ]
| Black/African/Caribbean |[ ]  Christianity |[ ]
| Mixed or multiple ethnic groups |[ ]  Hinduism |[ ]
| Asian |[ ]  Humanism |[ ]
| Other ethnic group |[ ]  Islam |[ ]
| Prefer not to say |[ ]  Judaism |[ ]
| Not asked |[ ]  Paganism |[ ]
|  | Sikhism |[ ]
|  | Other |[ ]
|  | Prefer not to say |[ ]
|  | Not asked |[ ]
|  |
| **Gender** |
| **Is your gender the same as assigned at birth?** | **Do you identify:** | **Sexual Orientation** |
|  |  | Heterosexual |[ ]
| Yes |[ ]  As a woman |[ ]  Gay |[ ]
| No |[ ]  As a man |[ ]  Bisexual |[ ]
| Prefer not to say |[ ]  In another way |[ ]  Lesbian |[ ]
| Not asked |[ ]  Prefer not to say |[ ]  Other |[ ]
|  | Not asked |[ ]  Not asked |[ ]
|  |  |  |  |
| **Carers** |
| Do you provide care for anyone (e.g. 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 term health issues or terminal illness? | Yes |[ ]
|  | No |[ ]
|  | Prefer not to say |[ ]
|  | Not asked |[ ]