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|  **Litigation Friend S 16 Referral Form Dorset****This form should be completed in full and returned.****PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE REFERRER TO ENSURE THAT FUNDING FOR THE SOLICITORS FEES HAS BEEN ARRANGED.*****Please complete all sections otherwise the referral will be returned to you and will delay the referral being processed; this includes the monitoring questions at the end of the form.*** |
| **REFERRER DETAILS** |
| Full name: | Job Title: |
| Address:  Telephone No.Mobile No. |
| **CLIENT INFORMATION** |
| Full name: | Known as: | Date of birth |
| Address at point of referralPostcode:Tel no:Mobile No.Contact Name at Referral Address: | Home address (if different)Postcode:Home Tel no:Mobile No.Contact Name at Home address: |
| **Nature of illness or impairment****(please indicate one or****more as appropriate)*** Learning disability
* Mental Illness
* Dementia
* Serious Physical Illness
* Acquired Brain Injury
* Unconscious State
* Other – Please give brief description
 | **Preferred communication method****(please indicate and give brief details as appropriate)*** English
* Another Spoken Language
* Pictures/Symbols
* Makaton/British Sign Language
* Gestures/Vocalisations/Facial expressions
* No Obvious Communication
* Other – Please specify
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| **DETAILS OF RELEVANT PROFESSIONALS** |
| **Name** | **Address** | **Connection to the client** |
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| **For a S16 referral please confirm how the solicitor’s fees will be paid?** |
| **Privately – The client will be paying the Solicitor’s fees with their own funds and this has been agreed.** |[ ]
| **Legal Aid – The client is eligible for Legal Aid Funding and this has been confirmed by the Local Authority/NHS Dorset (ICB).** |[ ]
| **Local Authority/NHS Dorset (ICB) – The Local Authority or NHS Dorset (ICB) has agreed to pay the solicitors fees up to and including the first hearing.** |[ ]
| **\*\*Without one of the above funding streams being confirmed,** **we are not able to provide a Litigation Friend.** |

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| **CAPACITY ASSESSMENT**A decision specific capacity assessment was completed on: DD/MM/YYName & Job Title of Assessor:  |
| **Please provide any important deadlines or meeting dates:**  |
| **Please state the advocacy need:** |
| **Signature of the decision-maker or authorised person:**NB If an electronic signature isn’t used, the return of this form is a presumption of a signature |  | **Date:** |

**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**

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| **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 |  |  |  |
|  |  | Not asked |  |  |  |
|  |  |  |  |  |  |
| **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 |  |
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| **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 or terminal illness? | Yes |  |
| No |  |
| Prefer not to say |  |