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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 referral  Postcode:  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/YY  Name & 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 | |  |