**Care Act Advocacy Service (adults) Referral Form**

**Portsmouth**

**Criteria:**

**The client must be a resident in Portsmouth at the time of the referral. We can only accept a referral if the person needing an advocate has given their consent. If the referrer believes they do not have the capacity to consent, they must give brief details on the ‘additional information’ section of the referral form.**

**The client must:**

**• have been assessed as having substantial difficulty in being involved in the process and**

**• not have anyone other than paid staff willing or appropriate to support them**

A referral may also be made where there is disagreement between the local authority and the appropriate person whose role it would be to facilitate the individual’s involvement, and there is agreement that the involvement of an independent advocate would be beneficial to the individual.

***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.***

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| **Has this client been formally assessed as having a substantial difficulty as defined** **in the Care Act 2014? Yes/No** |
| **Name and job title of assessor:** **Date of the assessment and issue for which they were assessed:** |
| **Has the client consented to the referral?** **(If no – provide details in additional information) Yes/No** |
| **Support required for: (please indicate as appropriate)** An independent advocate **must** be appointed to support and represent the person for the purpose of assisting their involvement if these two conditions are met and if the individual is required to take part in one or more of the following processes:* Needs Assessment
* Carers’ Assessment
* Preparation/Review of a Care and Support Plan or Support Plan
* Safeguarding Section 42 Enquiry/Review\*
* Appeal against a local authority decision under Part 1 of the Care Act

\*We are unable to provide advocacy unless a Section 42 enquiry has been opened |
| **Does the client have family or close friends appropriate to support them? Yes/No****If there are family and or friends why is an advocate needed?** Care Act Guidance state advocacy is needed where there is no other appropriate adult to help them. |
| **Client Information** |
| Name: | Date of Birth: |
| Address at point of referral:Postcode:Tel No. | Home address: (if different)Postcode:Home Tel No. |
| Contact Name at referral address if not client: | Contact Name at home address if not client: |
| **Nature of client’s illness or impairment:** (please tick one or more as appropriate)* Learning Disability
* Physical Disability
* Mental Ill Health
* Sensory Impairment
* Aging (Over 60)
* Dementia
* Acquired Brain Injury
* Autistic Spectrum Disorder
* Other, please specify
 | **Preferred Communication method:** (please indicate and give brief details as appropriate)* English
* Other Spoken Language
* Pictures/Symbols
* Makaton/British Sign Language
* Gestures/Vocalisations/Facial expressions
* No Obvious Communication
* Other – Please specify
 |
| **Is the Client a Carer?** Yes/No |
| **CONSENT Due to the Data Protection Act 1988, we need signed authorisation to say that the individual agrees to Swan Advocacy holding personal information (including the information provided on this referral**NB If an electronic signature isn’t used, the return of this form is a presumption of a signature**Signed Referrer Signed Client****Date:** |
| **Name of Local Authority Practitioner involved with this issue** |
| Name:  | Job title: |
| Organisation: | Team: |
| Address:Postcode: |
| Work no:Mobile no: | Email address: |
| **Additional information including need for advocacy support:**  |
| **Risk information:** 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:**  |
| **Referrer Name (if different to above)** |
| **Job title & Organisation:** |
| **Address:** | **Tel. No:****Email address:** |

**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** | **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** | **Sexuality** |
| **Client identifies as:** | **Client identifies as:** |
| Male |  | Queer |  |
| Female |  | Bisexual |  |
| Trans Man |  | Pansexual |  |
| Trans Woman |  | Gay |  |
| Intersex |  | Lesbian |  |
| Non-Binary |  | Heterosexual |  |
| Genderqueer |  | Asexual |  |
| Other |  | Other |  |
| Prefer not to say |  | 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 |  |