**Care Act Advocacy Service Referral Form – Pan Dorset**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria:**  **The client must be a resident in Dorset, Bournemouth, Christchurch or Poole 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.*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Has this client been formally assessed as having a substantial difficulty as defined in the Care Act 2014?** | | | | | | | | | | | | | | | | | | | | | | **Yes**  **No** | |
| Name of Referrer: | | | | | | | | |  | | | | Job Title: | | | | | |  | | | | |
| The issue for which they were assessed: | | | | | | | | | | |  | | | | | | | | | | | | |
| Has the client consented to the referral? | | | | | | | | | | | | | | | | | | | | | | **Yes**  **No** | |
| If no, please provide more details: | | | | | | | | | |  | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | | | | |
|  | | | | | | | Childs Needs Assessment | | | | | | | | | | | | | | | | |
|  | | | | | | | Childs Carers Assessment | | | | | | | | | | | | | | | | |
|  | | | | | | | Young Carers Assessment | | | | | | | | | | | | | | | | |
|  | | | | | | | Section 42 Safeguarding Enquiry/Review | | | | | | | | | | | | | | | | |
|  | | | | | | | Appeal against a local authority decision under Part 1 of the Care Act | | | | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | | | |
| **Does the client have family or close friends appropriate to support them?** | | | | | | | | | | | | | | | | | | | | | | **Yes  No** | |
| **If there are family 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: | | | | | | | | DD/MM/YYYY | | |
| Address at referral: | | | | | | | | | | | | | Home address: (if different) | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | |
| Postcode: | | | | |  | | | | | | | | Postcode: | | | | | |  | | | | |
| Tel No. | | | |  | | | | | | | | | Tel No. | | | |  | | | | | | |
| **Preferred Communication method (please indicate and give brief details as appropriate)** | | | | | | | | | | | | | | | | | | | | | | | |
|  | English | | | | | | | | | | | | |  | British Sign Language | | | | | | | | |
|  | Other spoken language | | | | | | | | | | | | |  | No Obvious communication | | | | | | | | |
|  | Pictures/symbols/Makaton | | | | | | | | | | | | |  | Gestures/vocalisations/facial expressions | | | | | | | | |
|  | Other | | | | | | | | | | | | |  | | | | | | | | | |
| If other, please specify: | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Is the client a carer? | | | | | | | | | | | | | | | | | | | | | | **Yes  No** | |
| **Name of Local Authority Practitioner involved with this issue** | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | |  | | | | | Job Title: | | | | |  | | | | | |
| Organisation: | | | | | | | |  | | | | | Team: | | | | |  | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| Work No. | | | | | |  | | | | | | | Email: | | |  | | | | | | | |
| Mobile No. | | | | | |  | | | | | | |
| Are you referring from the NHS Continuing Healthcare (CHC) Team? | | | | | | | | | | | | | | | | | | | | | | |  |
| **Additional information (including need for advocacy support):** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| **Risk information:** e.g. 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)** | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | Job Title: | | | | | | | |  | | | |
| Address: | | | | | | | | | | | | Organisation: | | | | | | | |  | | | |
|  | | | | | | | | | | | | Tel No. | | | | | | | |  | | | |
| Email: | | | | | | | |  | | | |
| **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 | | | |  | | |
|  | | | | 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 | | |  | |
|  | | Prefer not to say | | |  | Other | | |  | |
|  | | | | Prefer not to say | | |  | |
|  | |  | | | |  | | |  | |
| **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 | | |  |