

**CARE ACT**

**Advocacy Referral Form**

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| **Please note – Care Act referrals can only be made by Social Workers** |

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| If you require our IMHA, IMCA or generic Advocacy service, please complete the appropriate referral form which can be found in the ‘Downloads’ section of our webpage or contact us for more information [www.iane.org.uk](http://www.iane.org.uk) |

**Reason for Referral (please tick)**

|  |  |
| --- | --- |
| Care Assessment |  |
| Care Review |  |
| Care Planning |  |
| Safeguarding |  |
| If Safeguarding please state reason | |

|  |  |
| --- | --- |
| Without support, will the person have substantial difficulty being involved? | **YES/NO** |
| Is there an appropriate individual to support the person? | **YES/NO** |
| If you answered no to the first question and/or yes to the second question then a Care Act advocacy referral would not be appropriate. | |

|  |  |  |  |
| --- | --- | --- | --- |
| English |  | Gestures\facial expressions\vocalisations |  |
| Other spoken language |  | No obvious means of communication |  |
| BSL |  | Text/Email |  |
| Words\pictures\Makaton |  | Other (please state below) |  |
|  |  |  |  |

**Primary means of communication**

**Client Details**

Name……. ………………………………………………......................................................

D.O.B …………………… Age…..… Gender: M / F / O / prefer not to say (Please circle)

Person’s contact details: Translator required **YES/NO** (Please circle)

Address…………………….. ………………… Telephone numbers

…………….…….............................................. Home…………………………………………………….

………………….............................................. Mobile…………………….……………………………..

Postcode……………. ………………………….. Email…………………………………..…………………

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Does the person have a disability?** | | **YES** |  | **NO** |  | **Prefer not to say** |  |
| **If yes please tell us about the nature of their disability:** | | | | | | | |
| **Is the person neurodivergent?** | **YES** | |  | **NO** |  | **Prefer not to say** |  |

**Referrer’s Details**

Method of contact……………………………….. Date of referral……………………….......................

Name……………………………………………… Status/job title ………...……………………………..

Place of work…………………………………………………………………………………………………………

Contact number………………………………..… Email ……………………........................................

**Details of Other Professionals Involved (including referrer)**

|  |  |  |
| --- | --- | --- |
| Name | Relationship to Person | Contact Number |
|  |  |  |
|  |  |  |
|  |  |  |

**Further Information**

(Please circle)

|  |  |
| --- | --- |
| Is there any risk of violent or dangerous behaviour, or any other pertinent risks the advocate should be aware of? (i.e. security issues) | **YES/NO** |
| Is there a risk of exposure to infection the advocate needs to be aware of (i.e. MRSA)? | **YES/NO** |
| If yes to either of the above, please explain and attach any risk assessments: | |

|  |  |  |
| --- | --- | --- |
| Does the person know about this referral? | | **YES/NO** |
| Does the person have capacity to instruct an advocate? | | **YES/NO** |
| Location of person when referred (i.e. community, hospital) |  | |

**Brief details of the situation/issue that requires advocacy involvement:**

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\*Please continue on a separate sheet if necessary

Are there any deadlines or important meeting dates? …………………………………………………….......................................................................................

**Religion/belief: Which group do you / the referee most identify with? (Please cross box that applies)**

|  |  |  |  |
| --- | --- | --- | --- |
| Buddhist |  | Jewish |  |
| Christian |  | Muslim |  |
| Hindu |  | Sikh |  |
| No religion |  | Prefer not to say |  |
| In another way (please describe): |  | | |

**Sexual orientation: Which of the following options best describes you/ the referee? (please cross box that applies)**

|  |  |  |  |
| --- | --- | --- | --- |
| Heterosexual/straight |  | Bisexual |  |
| Homosexual |  | Prefer not to say |  |
| Not known |  | Other (please describe) |  |
|  | | | |

**Ethnic origin: Choose one option which best describes you / the referee’s ethnic group or background (please cross box that applies). Categories based on Census 2011 categories**

|  |  |  |  |
| --- | --- | --- | --- |
| Asian British/Bangladeshi |  | White British |  |
| Asian British/Indian |  | White Irish |  |
| Asian British/Pakistani |  | White Gypsy/Traveller |  |
| Asian British/Chinese |  | Other White background (please describe): |  |
| Any other Asian background (please describe): |  |
| Mixed Asian and White |  |
| Black British/Black African |  | Mixed Black African and White |  |
| Black British/Black Caribbean |  | Mixed Black Caribbean and White |  |
| Any other Black/African/Caribbean background (please describe) |  | Any other Mixed/multiple ethnic background (please describe): |  |
| Any other Ethnic group (please describe): |  | Prefer not to say/Not known/Not given |  |

**Country of origin/cultural identity: How do you describe you / the referee’s country of origin/cultural identity?**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| I confirm that I have consent from the client to make a referral to Advocacy or |  |
| I confirm I have the authority to make a referral for the client. |  |
| I understand and agree that the information I provide will be stored securely and used for monitoring purposes. Any identifiable information is kept confidential and secure. |  |
| I understand by ticking these boxes I confirm my agreement |  |

**Please return completed form to:**

Independent Advocacy North East, B14 Linskill Centre, Linskill Terrace, North Shields, Tyne and Wear NE30 2AY

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