# Rethink Advocacy Referral Form

| | | | |
|---|---|---|---|
| **Please note all fields must be completed or the form will be returned: this could delay an Advocate being allocated. Where Not Applicable please indicate by inserting N/A** | | | |
| **Date of Referral** | | | |
| **Client Details** | | | |
| Client Name | | Client DOB | |
| Home Address | | | |
| **Address at point of referral** (if different from above). If hospital, please include ward name/number | | | |
| Post code | | Local Authority/Borough | |
| Telephone | | Email | |
| GP Surgery the client is registered with | | GP Surgery contact number | |
| **Type of advocacy required (please tick only one box per referral)** | | | |
| Care Act Advocacy (ICAA) | | | |
| Independent Mental Capacity Advocacy (IMCA) | | | |
| Independent Mental Health Advocacy (IMHA) | | | |
| NHS complaints Advocacy (IHCA) | | | |
| Generic or community advocacy | | | |
| **If ICAA please tick referral reason (please only tick one box per referral)** | Needs Assessment | | |
| | Preparation of Care and Support Plan | | |
| | Safeguarding | | |
| | Review of Care and Support Plan | | |
| | Complaint/Appeal | | |

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If you wish to make any complaints about our service, please email us at advocacyreferralhub@rethink.org

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| | | |
|---|---|---|
| **If IMCA please tick referral reason (please only tick one box per referral)** | Serious Medical Treatment | |
| | Change of accommodation (over 28 days) | |
| | Adult protection | |
| | Care Review | |
| **If IMHA please tick referral reason (please only tick one box per referral)** | Detained under Mental Health Act | |
| | Conditional Discharge | |
| | Subject to Guardianship | |
| | Community Treatment Order | |
| | Considered for treatment to which Section 57 applies | |

| Details (please provide as much additional information as you can about the referral) |
|---|
| |

| If client **lacks** capacity, please complete this section | |
|---|---|
| Has a capacity assessment in relation to the decision being made been completed? | Yes/No |
| Name & job title of person who completed the assessment | |
| Date of assessment | |
| Is the assessment attached with referral? | Yes/No |

| If the person lacks capacity and a decision is being made in their best interest, please provide the details of the decision maker below | |
|---|---|
| Name of Decision Maker | |
| Job Title | |

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| | |
|---|---|
| Team and Department | |
| Local Authority/Borough | |
| Telephone | |
| Email | |

| | |
|---|---|
| If the client **has** capacity, please complete the section below | |
| Is the client aware of and consented to the referral for advocacy support? | Yes/No |
| If not please give details: | |

| |
|---|
| Please detail any risk issues the advocacy services needs to be aware of below, or confirm there are no known risks |
| |

| | | | |
|---|---|---|---|
| **Name and details of person completing this referral form** | | | |
| **Name** | | **Job Title** | |
| **Telephone No** | | **Email** | |
| **Relationship to client** | | **Date** | |

**IMCA and Care Act referrals, can only be made by a Health or Social Care Professional. Signing this referral allows the service to process the client's information, act on behalf of the client, create anonymised case studies and share anonymised case notes for advocacy qualification training purposes.**

**Additional information – Please put a X in those that apply**

| **Religion or spiritual belief** | | | | | |
|---|---|---|---|---|---|
| Buddhist | | Jewish | | Other Religion | |
| Christian | | Muslim | | No Religious Belief | |
| Hindu | | Sikh | | Do not wish to answer | |
| **Ethnicity** | | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| Asian or Asian British - Any Other Asian Background | | Mixed - Any other mixed background | | White - Any Other White Background | |
| Asian or Asian British - Bangladeshi | | Mixed - White and Asian | | White - British | |
| Asian or Asian British - Indian | | Mixed - White and Black African | | White - Gypsy or Irish Traveller | |
| Asian or Asian British - Pakistani | | Mixed - White and Black Caribbean | | White - Irish | |
| Black or Black British - African | | Do not wish to answer | | Not provided | |
| Black or Black British - Caribbean | | Other Ethnic Group - Any other ethnic group | | Do not wish to answer | |
| Black or Black British - Other Black Background | | Other Ethnic Group - Arab | | | |
| **Sexual orientation** | | | | | |
| Heterosexual / Straight | | Bisexual | | Not Provided | |
| Homosexual / Gay Man | | Other | | | |
| Lesbian / Gay Woman | | Do not wish to answer | | | |
| **Additional needs** | | | | | |
| Learning Disability | | Mental Illness | | Dementia | |
| Autism | | Acquired Brain Injury | | Other | |
| **Communication needs / preferences** | | | | | |
| Preferred language (please specify) | | English language | | Other spoken language (please specify) | |
| Preferred method of communication (please specify) | | Able to read | | British Sign Language | |
| Pictures / symbols | | Makaton | | Gestures / facial expressions | |
| Sounds / vocalisations | | No formal means of communication | | Other support needs | |
| Hearing impairment | | | | | |
| **Other** | | | | | |
| Pregnant /maternity Yes/No | | | | | |
| Gender | | Identifies as same sex as at birth | | Yes/No/Prefers not to answer | |
| Marital status | | | | | |
| Mental health diagnosis: | | | | | |

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| Details of any long-term physical health condition: |
| --- |
| |

**Once completed, please save this form and then click the button below.**

**Alternatively, please send to: advocacyreferralhub@rethink.org**

**Save and Send now**

**Any queries please call 0300 7900 559**

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