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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **It is important that as much information as possible is included in the referral form for us to asses eligibility. Please complete all fields with as much detail as possible or the referral form is at risk of being returned. This could delay an Advocate being allocated. Where ‘Not Applicable’ please indicate by inserting ‘N/A’.** | | | | | | | | | | | |
| **Date of Referral** | |  | | | | | | | | | |
| **Client’s Details** | | | | | | | | | | | |
| **Client’s Name/Surname:** | |  | | | | **Client \*DOB:** |  | | | | |
| **Client’s title e.g. Miss, Mrs, Mr etc:** | |  | | | | | | | | | |
| **Client’s Home Address:** | |  | | | | | | | | | |
| **Client’s (full) Postcode:** | |  | | | | | | | | | |
| **Address at point of referral:** | |  | | | | | | | | | |
| **If in a hospital setting, please specify:** | | **Hospital/Trust name:** | | | **Ward name:** | | **Ward number:** | | | | |
|  | | |  | |  | | | | |
| **Client’s telephone:** | |  | | | **Client’s email:** | |  | | | | |
| **Ordinary resident of which Local Authority:** | | **Camden** | | | Yes/No | | | | | | |
| **Islington** | | | Yes/No | | | | | | |
| **Wandsworth** | | |  | | | | | | |
| **Richmond** | | |  | | | | | | |
| **Other LA -please specify** | | |  | | | | | | |
| **If Homeless -please provide detail** | | |  | | | | | | |
| **Type of advocacy required** | | **Referral Reason** | | | | | **please tick ✓** | | | | |
| **ICSA** (Care Act) please tick referral reason | | **Needs Assessment under section 9 of the Care Act 2014** | | | | |  | | | | |
| **Carers assessment under section 10** | | | | |  | | | | |
| **Preparation of Care and Support Plan under section 25** | | | | |  | | | | |
| **Review of Care and Support Plan under section 27 (Placement Review)** | | | | |  | | | | |
| **Safeguarding under section 68** | | | | |  | | | | |
| **Other:** please clearly explain why an ICSA advocate is required | | | | |  | | | | |
| **IMCA** please tick referral reason | | **Serious Medical Treatment:** new treatment, stopping or withholding treatment | | | | |  | | | | |
| **Change of accommodation:** move to a hospital likely to exceed 28 days | | | | |  | | | | |
| **Change of accommodation:** move to residential home (or another residential placement) for period likely to exceed 8 weeks | | | | |  | | | | |
| **IMHA** please tick qualifying patient criteria: | | **Detained under Mental Health Act** | | | | |  | | | | |
| **Conditional Discharge** | | | | |  | | | | |
| **Subject to Guardianship** | | | | |  | | | | |
| **Community Treatment Order** | | | | |  | | | | |
| **Considered for treatment to which Section 57 or 58A includes people under 18** | | | | |  | | | | |
| **IHCAS** NHS Health Complaints: | | **N/A** | | | | |  | | | | |
| **Non-statutory Advocacy:**  Please contact us for eligibility & referral criteria.  When requesting non-statutory advocacy, please ensure the **‘Additional Needs’** section is completed below | | **N/A** | | | | |  | | | | |
| **Please provide dates of any meetings already planned:** | |  | | | | | | | | | |
| **Additional Needs:** Please provide as much additional information as you can about the referral explaining why advocacy is required. | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Please confirm below that there is no one else suitable to provide support. If friends or family are involved with the client, please explain why the decision has been made to involve an advocate: | | | | | | | | | | | |
|  | | | | | | | | | | | |
| If the 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 client 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:** | |  | | | | | | | | | |
| **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 safety issues the advocacy service needs to be aware of below, or confirm there are no known risks:** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Name and details of person completing this referral form** | | | | | | | | | | | |
| **Full Name:** |  | | | **Job Title:** | | | |  | | | |
| **Telephone No:** |  | | | **Email:** | | | |  | | | |
| **Name of:**  **Local Authority**  **or Hospital/Trust**  **or**  **Organisation** |  | | | **Name of:**  **Local Authority Department /Division/**  **SW Locality Team**  **or**  **Hospital/Trust Department** | | | |  | | | |
| **Relationship to client:** |  | | | **Date:** | | | |  | | | |
| **IMCA and Care Act referrals, can only be made by a Health or Social Care Professionals 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.** | | | | | | | | | | | |

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| **Demographic profile** |

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| --- | --- | --- | --- | --- | --- | --- |
| **\*Religion or (spiritual) belief - please tick ✓ one option** | | | | | | |
| Buddhist |  | Jewish | |  | Rastafarian |  |
| Christian |  | Muslim | |  | Any other Religion or belief (please specify) |  |
| Hindu |  | Sikh | |  | No Religion or belief |  |
| Not provided |  | Prefer not to say | |  | Unknown |  |
| **\*Race / Ethnicity - please tick ✓ one option** | | | | | | |
| **Asian or Asian British ethnic groups** | | | | | | |
| Bangladeshi |  | Chinese | |  | Indian |  |
| Pakistani |  | Filipino | |  | Any other Asian background (please specify) |  |
| Not provided |  | Prefer not to say | |  | Unknown |  |
| **Black or Black British ethnic groups** | | | | | | |
| Caribbean |  | Eritrean | |  | Ethiopian |  |
| Ghanaian |  | Nigerian | |  | Somali |  |
| Any other African background (please specify) |  | Any other Black background (please specify) | |  | Not provided |  |
| Prefer not to say |  | Unknown | |  |  |  |
| **Mixed ethnic groups** | | | | | | |
| White and Asian |  | White and Black African | |  | White and Black Caribbean |  |
| Any other Mixed / Multi-ethnic background (please specify) |  | Not provided | |  | Prefer not to say |  |
| Unknown |  |  | |  |  |  |
| **White ethnic groups** | | | | | | |
| British / English / Northern Irish / Scottish / Welsh |  | Greek/Greek Cypriot | |  | Gypsy/Irish Traveller |  |
| Irish |  | Kurdish | |  | Turkish/Turkish Cypriot |  |
| Any other White background (please specify) |  | Not provided | |  | Prefer not to say |  |
| Unknown |  |  | |  |  |  |
| **Other Ethnic groups** | | | | | | |
| Arab (please specify country) |  | Latin American (please specify country | |  | Any other Ethnic group (please specify) |  |
| Prefer not to say |  | Unknown | |  |  |  |
| **\*Sexual orientation - please tick ✓ one option** | | | | | | |
| Bisexual |  | Gay | |  | Heterosexual/  Straight |  |
| Lesbian |  | Use another Term (please specify) | |  | Prefer not to say |  |
| Not provided |  | Unknown | |  |  |  |
| **\*Disability – please tick ✓ those that apply** | | | | | | |
| Alcohol Dependency |  | Asperger Syndrome (without LD) | |  | Autistic Spectrum Disorder (without LD) |  |
| Bipolar Disorder |  | Cancer | |  | Cerebral Palsy |  |
| Complex Postural Conditions |  | COPD / Respiratory condition | |  | Deaf - BSL User |  |
| Deaf - Other sign language user (please specify) |  | Dementia | |  | Diabetes (Type 1) |  |
| Diabetes (Type 2) |  | Downs Syndrome | |  | Drug / substance misuse |  |
| Dual sensory disabilities - deaf and blind |  | Dysphagia | |  | Eating Disorder |  |
| Epilepsy |  | Head injury | |  | History of falls |  |
| LD - Global Learning Disability - Profound |  | LD - Global Learning Disability - Mild | |  | LD - Global Learning Disability - Moderate |  |
| LD - Global Learning Disability - Severe |  | LD - Specific Learning Difficulties | |  | Long Covid |  |
| Long term illness/condition |  | Memory | |  | Other Mental Health Disorder - please specify |  |
| Other Physical Health condition - please specify |  | Personality Disorder | |  | Pica |  |
| Post-Traumatic Stress Disorder |  | Schizoaffective Disorder | |  | Schizophrenia |  |
| Social or behavioural |  | Stroke | |  | Visual Impairment |  |
| Wheelchair user |  | Not Provided | |  | Prefer not to say |  |
| Unknown |  |  | |  |  |  |
| **Diagnosis – please complete details below** | | | | | | |
| Mental health: | | | | | | |
| Details of any long-term physical health condition: | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **Communication needs / preferences – please tick ✓ those that apply** | | | | | | |
| Able to read - specify which language |  | British Sign Language | |  | Deafblind fingerspelling |  |
| English language - spoken |  | Gestures / Facial expressions | |  | Lip reader |  |
| Makaton |  | No formal means of communication | |  | Other spoken language - please specify |  |
| Pictures / Symbols |  | Preferred language - please specify | |  | Preferred method of communication - please specify |  |
| Sign Supported English |  | Sounds / Vocalisations | |  | Speech to Text Reporting |  |
| Other support needs - please specify |  | Not Provided | |  | Unknown |  |
|  |  |  | |  |  |  |
| **\*Marriage and Civil Partnership - please tick ✓ one option** | | | | | | |
| Married |  | | Civil Partnership | | |  |
| Single |  | | Co-habiting | | |  |
| Divorced |  | | Not provided | | |  |
| Other (please specify) |  | | Unknown | | |  |
| **\*Pregnancy and Maternity - please tick ✓ one option** | | | | | | |
| Pregnant |  | | On Maternity | | |  |
|  |  | |  | | |  |
|  |  | |  | | |  |
| **\*Sex - please tick ✓ one option** | | | | | | |
| Female / Woman |  | | Male / Man | | |  |
| Non-Binary |  | | A different preferred term (please specify) | | |  |
| Not provided |  | | Prefer not to say | | |  |
| Unknown |  | |  | | |  |
| **\*Gender reassignment - please tick ✓ one option** | | | | | | |
| Consider themselves to be trans or to have a trans history / Yes |  | | Do not consider themselves to be trans or to have a trans history / No | | |  |
| Has had gender reassignment |  | | Identify as same sex as at birth | | |  |
| Not provided |  | | Prefer not to say | | |  |
| Unknown |  | | Unsure | | |  |
| **Caring responsibilities - please tick ✓ one option** | | | | | | |
| Carer - Unknown Capacity |  | | Caring but not living with person | | |  |
| No Caring Responsibility |  | | Not provided | | |  |
|  |  | |  | | |  |
| **Please return this referral form to:**  **Camden & Islington Service** [**candi@rethink.org**](mailto:candi@rethink.org) **or**  **Wandsworth & Richmond Service** [**wandradvocacy@rethink.org**](mailto:wandradvocacy@rethink.org)  **Any queries please call 0300 7900 559 and select Option 2** | | | | | | |