**CARE ACT ADVOCACY REFERRAL FORM**

**\* = compulsory question**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF PERSON BEING REFERRED** | | | | | | |
| **Forename: \*** |  | | | | **Home Address and Post Code: \*\*** |  |
| **Surname: \*** |  | | | |
| **Date of Birth: \*** |  | | | |
| **Contact no:** |  | | | |
| **Other contact No:** |  | | | | **Address and Post Code at Time of Referral (if different)**  **\*\*** |  |
| **Email:** |  | | | |
| **Can voicemail messages be left?** | **Home** | **Y/N** | **Mobile:** | **Y/N** |
| **Is this person due to be discharged from hospital? \*** | | | | **Y/N** |

|  |  |
| --- | --- |
| **ACCESSIBILITY INFORMATION** | |
| **Preferred Language\*** |  |
| **Access Needs and other requirements\*** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **DEMOGRAPHIC INFORMATION**  *This information is used for monitoring purposes and to signpost service users to relevant services. Any information given should be determined by the person being referred, given voluntarily, and will be stored confidentially in line with data protection laws.* | | | |
| **Gender:** |  | **Faith or Religion:** |  |
| **Ethnicity:** |  | **Sexual Orientation:** |  |

|  |  |
| --- | --- |
| **SAFEGUARDING** | |
| **Are there any known risks to working with this individual? \*** |  |

**QUALIFYING CRITERIA**

Eligibility criteria for independent advocacy under section 67 & 68 of the Care Act. Please see our [Guidance notes](https://www.manchesteradvocacyhub.co.uk/care-act-advocacy/) for further details.

**What does the individual need advocacy support with? \***

|  |  |  |
| --- | --- | --- |
| Assessment (a needs assessment or a carers assessment) | Yes | No |
| Review of a care and support or support plan | Yes | No |
| Care and support planning | Yes | No |
| Safeguarding – Safeguarding Adult Review | Yes | No |
| Safeguarding - Subject to a S42 Safeguarding Enquiry. | Yes | No |

|  |  |  |
| --- | --- | --- |
| **Does the person have substantial difficulty in being fully involved in the above process/processes?** \* | Yes | No |
| **Does the person have an appropriate adult willing and able to facilitate their involvement in the process/processes and does the person consent to their involvement?** \* | Yes | No |
| If ticked ‘**yes’** please explain why this referral is necessary: | | |
|  | | |

**ADVOCACY NEEDS**

|  |  |  |
| --- | --- | --- |
| **CAPACITY ASSESSMENT** | | |
| Has a time and decision specific capacity assessment been carried out **\*** | Yes | No |
| If YES, what date was the capacity assessment undertaken? **\*** |  | |
| Completed by: **\*** | | |
| Outcome of capacity assessment (Please detail below the ways in which the person being referred lacks capacity remembering that capacity is issue-specific)\*: | | |
|  | | |

|  |  |
| --- | --- |
| Yes | No |

**Does the person have capacity to consent to the referral? \***

|  |  |
| --- | --- |
| Yes | No |

**Has the person consented to this referral? \***

**Provide details of advocacy needs\*:**

|  |
| --- |
|  |

**Provide details of any forthcoming meeting dates:**

|  |
| --- |
|  |

**REFERRER DETAILS\***

*By signing you agree to Gaddum keeping this information stored on a secure electronic case recording system, computer, and paper filing system. You confirm you are providing this information and asking for this referral in the client’s best interests.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Designation:** |  |
| **Organisation:** |  | **Contact No:** |  |
| **E-mail Address:** |  | **Date of referral:** |  |
| **Signature:** |  | | |

**INSTRUCTION**

Under the Care Act we must seek instruction from the lead professional before accepting this referral. This could be: the allocating social worker or the social worker conducting the Safeguarding enquiry.

**If the lead professional is not the same as the referrer, please provide their details below:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Designation:** |  |
| **Organisation:** |  | **Contact No:** |  |
| **E-mail Address:** | **Date of referral:** | | |
| **Does this person consent to be contacted?** | | Yes  No | |

**Please submit this fully completed referral form via one of the following methods:**

|  |  |
| --- | --- |
| **Password protect the file and send to:** | [**advocacy@gaddum.org.uk**](mailto:advocacy@gaddum.org.uk) |
| **Submit via Egress to:** | [**advocacy@gaddum.org.uk**](mailto:advocacy@gaddum.org.uk) |
| **Submit via secure email for NHS Staff:** | [**gaddum.centre@nhs.net**](mailto:gaddum.centre@nhs.net) |