**INDEPENDENT HEALTH COMPLAINTS ADVOCACY**

**PROFESSIONAL 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** |

|  |  |
| --- | --- |
| **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** | |
| **Any Known Risks? \*** |  |

**DETAILS OF THE COMPLAINT**

**Is the complaint about NHS funded care or treatment?**

*This service only provides IHCA support to people wishing to make a complaint about NHS treatment they received in line with NHS Regulation 2009.*

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

**Provide details of complaint and patient details if applicable**

|  |
| --- |
| * *Name and D.O.B. of patient.* * *Name of NHS organisation complaint is about (GP Surgery, Dentist, Hospital, etc).* * *Briefly explain what happened.* * *What action has already been taken to resolve the complaint?* * *What support is needed?* |

Has the client consented to this referral? Yes  No

Is the client happy for us to discuss their complaint with you? Yes  No

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

|  |
| --- |
|  |

**Provide details of any risks the advocacy service needs to consider:**

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|  |

**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:** |  | | |

**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) |