# Referral Form to Independent Advocacy for Care Advocacy Assessment

#### *Data supplied to us in this form will be processed in accordance with our* Data Protection Policy.

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| Details of the individual you are referring |
| **First Name** |  | **Last Name** |  |
| **Date of Birth** |  |
| **Current Address and Postcode***(if hospital, please include ward name; if prison please include wing)* |  |
| **Home Address and Postcode** *(if different to current address)* |  |
| **Email** |  |
| **Phone number** |  |

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| **Referrer’s Details** |
| **Job Title** |  |
| **Full Name** |  |
| **Email address**  |  |
| **Organisation** |  |
| **Work address** |  |
| **Profession** |  |  |  |  |
| **Phone/Mobile Number** |  |

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| Reason for Care Advocacy Referral |
| For an individual to be eligible for an advocate, **ALL THREE** of the following must apply:1. The individual is going through one of the processes listed in the first question below.2. Without support, the individual will have substantial difficulty in being involved in a decision. 3. The individual does not have any appropriate, able and/or willing family or friends to support the individual’s active involvement. |
| **What process is taking place?** |
| Social care needs assessment |[ ]  Safeguarding Enquiry (to support victims of alleged abuse) |[ ]
| Care review  |[ ]  Care planning, following on from one of these processes |[ ]
| Carer’s assessment |[ ]  Other |[ ]
| **Further details:**  |
| **What meetings does the advocate need to attend?***(i) Please provide the title of the meeting and the date. You can add multiple meetings.***Names and dates of meetings**      |
| **What does the individual find challenging?** |  |
| Understand information necessary to fully engage with care and support processes |[ ]  Weighing up information as part of the process of being involved |[ ]
| Retain information for long enough to be fully involved |[ ]  Communicate their wishes and views |[ ]
| **Further details about any challenges the individual will have in being involved:**  |

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| **Does the individual have an appropriate adult to support them?** | Yes [ ]  No [ ]  |
| **If yes, who is the appropriate adult:** |

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| **What formally diagnosed conditions or disabilities does the individual you are referring have?** |
| Acquired brain injury  |[ ]  Sensory impairment  | [ ]   |
| Autistic spectrum diagnosis |[ ]  Substance misuse/addiction |[ ]
| Dementia |[ ]  Physical disability |[ ]
| Mental health condition |[ ]  Stroke |[ ]
| Neurological conditions |[ ]  Learning disability | [ ]  |
| **Does the individual have any additional needs, for example communication or physical needs?** *(Please select all that apply)* |
| Need an interpreter |[ ]  Sight impairment |[ ]
| Hearing Impairment  |[ ]  Prefer information written down |[ ]
| Other |[ ]   |  |
| Further Details |   |  |
| **Has the individual you are referring requested an advocate?** | Yes [ ]  No [ ]  |
| **If yes, do they require a same-gender advocate?** | Yes [ ]  No [ ]  |
| **Has the individual agreed to this referral?** | Yes [ ]  No [ ]  |
| **If No, please explain?** |
| **Please detail any risk issues or incidents the Advocacy service should be aware of:** |

**Please email the completed form to** patricia@myvoice.org.je

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| Diversity Monitoring |
| *We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the individual you’re referring, you can help us improve what we offer.* |
| What is the gender of the individual you are referring? |
| Male [ ]  | Female [ ]  | Non-binary [ ]  | Prefer not to say [ ]  |
| **What is their ethnic group?** |
| White British [ ]   | Portuguese [ ]  | Polish [ ]  | Black, African/Caribbean [ ]  | Black, British [ ]  | Asian [ ]  |
| Other:  |  |  | Prefer not to say [ ]  |  |  |