

 **Care Act Referral Form**

referral@advocacyhub.org.uk

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| **Name:** |  |
| **Current address:**(home, hospital, residential home) |  |
| **Home address:** (if applicable) |  |
| **Telephone:** |  | **Mobile:** |  |

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| --- | --- | --- | --- | --- | --- |
| **Date of birth:** |  | **Gender:** |  | **Ethnicity:** |  |

|  |  |  |
| --- | --- | --- |
| **Who is the referral for?** | **Yes**  | **No** |
| A person with care and support needs |  |  |
| A carer with support needs |  |  |
| A young person with care needs in transition |  |  |
| A young carer with support needs |  |  |

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| --- | --- | --- | --- |
| **Does the person have capacity to consent to the referral?** | Yes  | No | Unsure |
| **If Yes please confirm the person has given consent to the referral and for the hub to hold their personal information**  | Yes  |

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| --- | --- | --- |
| **Is this an urgent referral?** | Yes  | No |

 **Eligibility criteria for Care Act Advocacy**

**What does the person need advocacy support with?**

Assessment Care and support planning

(Including carers assessment)

 Care and support review Safeguarding

**Would the person have substantial difficulty in being involved with the process without the support of an advocate?** (see guidance notes)

Yes No Unsure

**Does the person have an appropriate adult who would be willing and able to facilitate and support their involvement?** (see guidance notes)

Yes No Unsure

**Has the person had previous support from an IMCA**

Yes No Unsure

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| **Plea Please give brief description of advocacy issue** |

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| --- |
| **Plea Please provide any forthcoming meeting dates and any other relevant information** |

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| **Please give brief details on any specific needs ie communication, sensory, physical:** |

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| **Please detail any risk or incidents the advocacy service should be aware of:** |

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**Referrer details**

|  |  |
| --- | --- |
| **Name:** |  |
| **Role/relationship to person**  |  |
| **Organisation** (if applicable) |  |
| **Team** |  |
| **Contact number:** |  | **Mobile:** |  |
| **Email address:** |  |

**Referrer’s statement**

*I believe the person is eligible for support from a Care Act Advocate and I am authorised by my organisation to make this referral.*

Signed: Date:

Please email this form (password protected) to referral@advocacyhub.org.uk

**Before sending please complete the consent declaration at the end of this form if appropriate**

You will be contacted within **three to five working days** of receipt.

For more information contact **Speak Up Advocacy Hub** on **01925 246 888.**

**Consent from referrer if person lacks capacity**In order to be compliant with the data protection legislation and good practice, we require signed authorisation to say that people agree to the Speak Up Advocacy Hub holding personal information (including the information on this form).

The person being referred is deemed to lack capacity, therefore, the referrer must sign to say they are referring and providing information in the person’s best interests, acknowledging that the person referred lacks capacity to make this decision.

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| --- |
| I am requesting a Care Act advocate to undertake this work.  I am providing this information and asking for this referral in the client’s best interests: |
| **Referrer’s signature** |  | Date: |