**Care Act Referral - Form**

Referral date …………………… Received date …………………

Please follow the **Care Act Referral Guidance Information** sheet to confirm that you are making an appropriate referral.

**CLIENT DETAILS**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  | Gender *(Please tick)* | F |  | M |  |
| Current Location  |  |
| Post code |  |
| Permanent Address |  |
| Post code |  |
| Telephone numbers |  |
| Does the client have **any** disabilities? |  |

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| --- |
| **Client Ethnic Background** |
| White British |  | White Irish |  | White Gypsy / Irish Traveller |  |
| Other White background |  | Mixed / Multiple Ethnic Groups: White & Black Caribbean |  | Mixed / Multiple Ethnic Groups: White & Asian |  |
| Mixed / Multiple Ethnic Groups: White & Black African |  | Mixed / Multiple Ethnic Groups: other  |  | Asian / Asian British: Indian |  |
| Asian / Asian British: Pakistani |  | Asian / Asian British: Bangladeshi |  | Asian / Asian British: Chinese |  |
| Asian / Asian British: other |  | Black / African / Caribbean / Black British: African |  | Black / African / Caribbean / Black British: Caribbean |  |
| Black / African / Caribbean / Black British: other |  | Other Ethnic Group: Arab |  | Other Ethnic Group: other |  |
| Any identified religious, cultural or spiritual needs? |  |

**How does the person prefer to communicate?**

|  |
| --- |
|  |

**REFERRAL DETAILS**

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| Is this a self-referral? *(please tick)* |
| YES |  | NO |  |
| Northumberland Independent Advocacy Service (NIAS) has a duty to ensure the safety of its workers. In accordance with the Data Protection Act we reserve the right request information from third parties regarding any risk. For further information please contact NIAS.  |

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| **If this is not a self-referral please fill in details below:** |
| Is this a first referral?*(Please tick)* | YES |  | NO |  | NOT KNOWN |  |
| Referrer Name |  |
| Position/Role |  |
| Address |  |
| Postcode |  |
| Telephone, Email and Fax number |  |
| **Name of Care Manager/ Coordinator or social worker** |  |
| Address |  |
| Postcode |  |
| Telephone, Email and Fax number |  |

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| --- | --- |
| Please provide name, practice and contact details of GP |  |
| Has the patient been informed a referral is being made to the Advocacy service? | YES |  | NO |  |
| Has the client consented to the referral to the Advocacy service? | YES |  | NO |  |
| Does the patient have capacity to instruct a Care Act Advocate? | YES |  | NO |  |
| If you have answered NO to any of these questions, please explain why, providing details of any capacity assessment |  |

**Please complete fully**

**Issue:** Advocacy support required regarding:

|  |  |  |  |
| --- | --- | --- | --- |
| Assessment process |  | Care & support planning |  |
| Care and support review |  | Safeguarding enquiry |  |
| Safeguarding review |  | Appeals / complaints re care and support |  |
| Young people approaching transition to adult services |  |

**Eligibility** **Substantial Difficulty – please indicate all that apply**

|  |  |
| --- | --- |
| Understanding relevant information |  |
| Retaining information |  |
| Using / weighing up the information (as part of being involved in the process) |  |
| Communicating their wishes, views and feelings |  |

**Eligibility**             **INappropriate or UNaVAILABLE SUPPORT**

|  |  |
| --- | --- |
| Appropriate person declined the role |  |
| Person requiring support refuses the support of the person |  |
| Potential appropriate person has their own strong views on care and support that differs from the person requiring care and support |  |
| Is or may be involved in abuse of the person requiring support |  |

**Advocacy             CARE ACT ADVOCATE INVOLVEMENT**

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| --- |
| Please include brief details of the situation that requires Care Act advocate involvement: |
|  |
| Are there any deadlines or important meeting dates? |
|  |

**RISK ASSESSMENTS**

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| Please tick the box where the client has shown signs of risk. **Please include copies of up-to-date risk assessments**, e.g. FACE, when submitting the referral |
| Suicide tendencies |  | Lack of insight |  |
| Deliberate self-harm |  | Hostage taking |  |
| Self-neglect |  | Housing problems |  |
| Physical aggression without a weapon |  | Drug and alcohol misuse |  |
| Physical aggression with a weapon |  | Misuse of medication |  |
| Violent behaviour |  | Physical Health |  |
| Verbal aggression |  | Social Isolation |  |
| Criminal record |  | Lack of family support |  |
| Offending behaviour |  | Harassment/bullying (safeguarding) |  |
| Child protection issues |  | Risk to service user |  |
| Inappropriate behaviour (describe below) |  | Financial difficulties |  |
| Arson |  | Relationship difficulties |  |
| Non-compliance with care plan |  | Other – Please specify below |  |
| Please explain risks and include copies of assessments |

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| **Because of the Data Protection Act, a signature is required to say that you agree to the Northumberland Independent Advocacy service holding personal information, (including this form), on a secure electronic case management system, a computer, and in a paper filing system. It is the policy of the Adapt (North East) Advocacy Service that all personal data will be held in accordance with the principles and requirements of the General Data Protection Regulations and other relevant legislation, and that procedures will be put in place to ensure fair processing of data relating to individuals. Northumberland Independent Advocacy service is a free and confidential service. You can request further information on our Privacy and Confidentiality policies by contacting our main office. Please find contact details below.** |

**The client:** *I agree that the information on this form can be securely stored by Adapt (North East) Advocacy service on a secure electronic case recording system, computer and paper filing system.*

CLIENT SIGNATURE PRINT NAME DATE

**The referrer:** *I would like a Care Act Advocate to do this work. They can keep this information stored on a secure electronic case recording system, computer and paper filing system. I am providing this information and asking for this referral in the client’s best interest.*

REFERRER SIGNATURE PRINT NAME DATE

**PLEASE RETURN THIS FORM TO:**

**Secure email:** advocacy@adapt-tynedale.cjsm.net or advocay@adapt-tynedale.org.uk if using Egress Switch

Northumberland Independent Advocacy Service, Adapt (North East), Burn Lane, Hexham, Northumberland, NE46 3HN. **Tel:** 01434 600599 **Fax:** 01434 605251