This referral form is for all types of advocacy. You can complete this form on your own behalf (self-referral) or on behalf of someone else. Parts 1 and 2 **must** be completed as a minimum. Then depending on the advocacy required please complete other relevant parts. Incomplete forms may result in delays in allocating an advocate.

Email referrals securely to advonet.office@advonet.cjsm.net or you can password protect the form and email to [office@advonet.org.uk](mailto:office@advonet.org.uk) with the password emailed separately.

**Part 1: Type of Advocacy Required**

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| **Advocacy Required** | Choose an item. | | |
| How did you hear about this service? | Choose an item. | Date of referral | Click or tap to enter a date. |

**Part 2: Referral Information**

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| 1. **Relevant Person’s Details:** (this is the person who needs advocacy) | | | | | | | | | |
| Name | | | Click or tap here to enter text. | | | | | | |
| Home (usual) Address | | | Click or tap here to enter text. | | | | | | |
| Current Address or Location | | | Click or tap here to enter text. | | | | | | |
| Preferred contact method | | | Choose an item. | | | | | Click or tap here to enter text. | |
| Contact number | | Click or tap here to enter text. | | Can we leave a message? | | | | | Choose an item. |
|  | | | | | | | | | |
| Date of Birth | Click or tap to enter a date. | | | | Gender | Choose an item. | | | |
| Ethnicity | Choose an item. | | | | | | | | |
| Religion | Choose an item. | | | | Sexuality | Choose an item. | | | |
| Consent to make a referral for advocacy. | | | | | Choose an item. | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| 1. **Reason for advocacy referral**? (Please include a summary of the advocacy issue/decision being made, upcoming meeting dates, deadlines, priority areas etc) | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | |
| 1. **Referrer Details:** | | | | | | | | | |
| Name | Click or tap here to enter text. | | | | Job Title | | Click or tap here to enter text. | | |
| Employer | Choose an item. | | | | | | | | |
| Secure email | Click or tap here to enter text. | | | | Tel No: | | Click or tap here to enter text. | | |
| Place of work (inc address): | | | Click or tap here to enter text. | | | | | | |

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| 1. **Friends and/or family:** (Is there an appropriate person to support the person’s involvement?) | | |
| Is there anyone (e.g. friend/relative) who you are consulting with? | | Choose an item. |
| What is their relationship to the person requiring advocacy | | Click or tap here to enter text. |
| What are their contact details? | Click or tap here to enter text. | |
| Are there any current **Risk Issues** we need to be aware of? | | Choose an item. |
| Click or tap here to enter text. | | |

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| 1. **Other relevant information about the person requiring advocacy.** | |
| Any support needs? | Choose an item. |
| Other support needs? | Choose an item. |
| Is the person a carer? | Choose an item. |
| How does the person communicate? | Choose an item. |
| What is the person’s first language? | Click or tap here to enter text. |
| Other relevant information? | Click or tap here to enter text. |

**Part 3: Independent Mental Capacity Advocacy (IMCA)**

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| --- | --- | --- | --- | --- | --- |
| 1. **What is the main reason for this referral?** | | | | | |
| Choose an item. | | | | | |
| Has a capacity assessment been carried out? | | | Choose an item. | | Click or tap to enter a date. |
| Please confirm that there are **no** people, (other than paid people) who are appropriate to consult with? | | | Choose an item. | | |
| Click or tap here to enter text. | | | | | |
| 1. **Please indicate the Serious Medical Treatment you are considering:** | | | | | |
| Medical Treatment | Choose an item. | | | | |
| Other medical treatment: Click or tap here to enter text. | | | | | |
| Will the proposed procedure involve a General Anaesthetic (GA)? | | | | | Choose an item. |
| Is the person currently an inpatient? | | Choose an item. | | Hospital | Click or tap here to enter text. |
| Ward / Direct Telephone Number | | Click or tap here to enter text. | | | |
| 1. Decision Maker Details (if the referrer is the decision maker please tick this box) | | | | | |
| Click or tap here to enter text. | | | | | |

**Part 4: Deprivation of Liberty Safeguards (DoLS)**

|  |  |
| --- | --- |
| Main reason for referral | Choose an item. |
| Has a DoLS application been made for the person requiring advocacy? | Choose an item. |
| Does the person have a Relevant Person’s Representative? (RPR) | Choose an item. |
| Click or tap here to enter text. | |

**Part 5: Care Act Advocacy Referrals (CAA)**

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| --- | --- |
| 1. **Is the person going through a social care process? Please select main process below.** | |
| Choose an item. | |
| Does the person requiring advocacy have **substantial difficulty** in engaging with, or understanding the referral issue? (these are: difficulty understanding, retaining, using / weighing up information or communicating their wishes and feelings) | Choose an item. |
| Does the person requiring advocacy have an appropriate person to support them? | Choose an item. |

**Part 6: Independent Mental Health Advocacy (IMHA)**

*If the patient is an informal (voluntary) patient, please make a referral for Community Advocacy.*

|  |  |  |
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| 1. **Qualifying Patient.** | | **Section Start Date** |
| The person is detained under the Mental Health Act 1983. | | Click or tap to enter a date. |
| Type of Section | Choose an item. | |
|  | | |
| 1. **Additional Contacts:** (Responsible Clinician (RC) / Nearest Relative etc) | | |
| Click or tap here to enter text. | | |

## Glossary of Terms

*Non-binary* refers to individuals who don’t see themselves as either male or female. Individuals identifying as non-binary may ask you to use gender neutral pronouns such as they/their rather than he/she. Please do not ask non-binary individuals the sex or gender assigned to them at birth as this is irrelevant.

*Trans* male/female refers to individuals who are transitioning to the gender they identify with.

*Pansexual* refers to individuals who are romantically, emotionally, sexually attracted to people regardless of their sex and gender identity.