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 with the password emailed separately.

**Part 1: Type of Advocacy Required**

|  |  |
| --- | --- |
| **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)**

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| 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.*

|  |  |
| --- | --- |
| 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.