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| A close up of a logo  Description automatically generated | **Advocacy Referral Form**  **Care Act Advocacy** |

This form is for our [**Care Act Advocacy**](https://advonet.org.uk/services/care-act-advocacy/) service. You must complete all relevant questions to ensure that your advocacy referral is processed. Any incomplete information

Once completed, please email this referral form to [**office@advonet.org.uk**](mailto:office@advonet.org.uk). Please note that sensitive data is emailed to us at your own risk. If you would like to give information over the phone or discuss a secure way to make an advocacy referral, please call our First Contact Team on **0113 244 0606**.

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| Date of Referral (DD/MM/YYYY) | 23/10/2023 |
| Your Name |  |
| Your Email Address |  |
| How did you hear about this service? | Choose an item. |

**Part 1: Is the person going through a social care process?**

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| Please select main process in the list to your right. A person must be going through one of these processes to be eligible for Care Act Advocacy (See [Section 7.19 of the Care and Support Statutory Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf)) | 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)  See [Section 7.10-7.16 of the Care and Support Statutory Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf) for more information. | Choose an item. |
| Does the person requiring advocacy have an appropriate person to support them?  A person would usually not have an appropriate person to support them in order to be eligible for Care Act Advocacy (see [Section 7.32-7.42 of the Care and Support Statutory Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf)) | Choose an item. |
| Please provide the person’s contact details if answering “Yes” to the previous question. |  |
| Is the person you are referring aware you are making this referral? | Choose an item. |
| If answering “No” or “Not yet” to the previous question, please tell us why in the box to the right. |  |

**Part 2: Relevant Person’s Details (the person who needs advocacy)**

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| Name |  |
| Current Address/ward/unit |  |
| Postcode |  |
| Home Address (where you usually live) |  |
| Preferred contact method | Choose an item. |
| Contact number |  |
| Can we leave a message? | Choose an item. |

**Part 3: Reason for Advocacy Referral?**

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| Please include a summary of the advocacy issue/decision being made, upcoming meeting dates, deadlines, priority areas etc. |  |

**Part 4: Referrer Details**

|  |  |
| --- | --- |
| Name |  |
| Job Title |  |
| Employer | Choose an item. |
| Phone number: |  |
| Place of work (including address) |  |

**Part 5: Friends and/or family (Is there an appropriate person to support the person’s involvement?)**

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| Is there anyone (e.g. friend/relative) who you are consulting with? |  |
| What is their relationship to the person requiring advocacy? |  |
| What are their contact details? |  |
| Are there any current Risk Issues we need to be aware of? | Choose an item. |
| Please write any details of Risk Issues in the box to the right: |  |

**Part 6: Other relevant information about the person requiring advocacy**

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| If you / the client has any support needs e.g. communication, please write them down in the box on the right. |  |
| What is the person’s first language? |  |
| Are there any additional communication or other needs not already mentioned e.g. needing advance notice of meeting dates/times? |  |

The following information is collected to help us create equal opportunities for individual’s resident within our local communities. We use this information anonymously to identify if the diversity of the people accessing our services fully reflects the communities we serve. If you prefer not to answer, please select that option.

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| Date of Birth – we ask for this information as some of our services are for specific ages (DD/MM/YYYY) |  |
| Gender | Choose an item. |
| Gender – other: Please tell us |  |
| Is their gender the one you were assigned at birth? | Choose an item. |
| Ethnicity | Choose an item. |
| Ethnicity – other: Please tell us |  |
| Religion | Choose an item. |
| Religion – other: Please tell us |  |
| Sexuality | Choose an item. |
| Sexuality – other: Please tell us |  |
| Disability – for monitoring and equal opportunity purposes, please let us know if the client has any of the following disabilities/impairments by ticking the relevant boxes | Acquired Brain Injury  Autism Spectrum Condition  Blind / Partially Sighted  Cognitive Impairment  Deaf / Partial Hearing  Dementia  Learning Disability  Long-Term Health Condition  Mental Health Needs  Older Person (Frailty)  Physical Condition / Illness |
| Is the client disabled in any other way not listed above? If so, please write in this box. |  |

## **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.