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| A close up of a logo  Description automatically generated | **Advocacy Referral Form**  **1.2 Representative** |

This form is for our [**1.2 Representative**](https://advonet.org.uk/services/independent-mental-capacity-advocacy-imca/) service. You must complete all relevant questions to ensure that your advocacy referral is processed. Any incomplete information will result in a delay in your referral being processed. You must also attach the most recent copy of the client’s care plan (this should be dated within the last three months) – failure to do so may delay allocation of a 1.2 Representative.

NB Referrals for a 1.2 representative need to come from a legal or social care professional only. If you need assistance, or have questions about this, please call The Advonet Group on **0113 244 0606**.

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**.

|  |  |
| --- | --- |
| Date of Referral (DD/MM/YYYY) | Click or tap to enter a date. |
| Your Name |  |
| Your Email Address |  |
| How did you hear about this service? | Choose an item. |

**Part 1: What is the main reason for this referral?**

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| Please provide details on the stage of care planning for the person requiring a 1.2 Rep  Examples might include:   * Client has been in placement for a long time but the plan has been reviewed and this is the first application for a COP DOL * Client has moved to a new placement and the social worker is completing the DOLS application * An application has been made to the court and they require a witness statement (COP24) * The client already has a COP DOL in place but this is coming up for review |  |

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| **Have the following been completed? If answering ‘Yes’, please attach** | | | |
|  | Yes | No | In process |
| COPDOL10 Application form |  |  |  |
| Capacity Assessment |  |  |  |
| Mental health assessment |  |  |  |
| Care plan |  |  |  |
| Best Interests form |  |  |  |
| Risk assessment |  |  |  |
| Placement plan |  |  |  |

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

|  |  |
| --- | --- |
| Name |  |
| Current Address |  |
| Postcode |  |
| Home Address (where the person usually lives) |  |
| Preferred contact method | Choose an item. |
| Contact number |  |
| Can we leave a message? | Choose an item. |
| Is the relevant person aware this referral is being made? | Choose an item. |

**Part 3: Referrer Details: Tell us a bit more about yourself**

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

**Part 4: Any other key contacts e.g. solicitor or social worker or manager of support provider**

|  |  |
| --- | --- |
| Name of Leeds City Council Solicitor |  |
| Job Title |  |
| Contact Number |  |
| Contact Email |  |
| Place of Work (including address) |  |

|  |  |
| --- | --- |
| Name of Social Worker/ Manager of Support Provider |  |
| Job Title |  |
| Contact Number |  |
| Contact Email |  |
| Place of Work (including address) |  |

|  |  |
| --- | --- |
| Name of other contact |  |
| Job Title |  |
| Contact Number |  |
| Contact Email |  |
| Place of Work (including address) |  |

**Part 5: Risk Issues**

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| 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.

|  |  |
| --- | --- |
| The client’s 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 they 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 person 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.