# Care Act advocacy referral form

## For referrals from professionals

#### *Text field boxes will expand as you type. Data supplied to us in this form will be processed in accordance with our* [*Privacy Notice*](https://www.voiceability.org/privacy-policy/)*. Care Act referrals should be made by a social care professional.*

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| 1. Reason for Care Act advocacy referral | | | | | | |
| *(i)For a person to be eligible for a Care Act advocate, ALL THREE of the following must apply:*  *1. The person is going through one of the processes listed in the first question below.*  *2. Without support, the person will have substantial difficulty in being involved in a decision.*  *3. The person does not have any appropriate, able and willing family or friends to support the person’s active involvement.* | | | | | | |
| **1. What process is taking place?** | | | | | | |
| Social care needs assessment |  | | S42 safeguarding investigations (to support victims of alleged abuse) | | |  |
| Care review |  | | Safeguarding Adults Review (SAR) | | |  |
| Carer’s assessment  *(i) We do not support carer’s assessments in Liverpool or Sefton* |  | | Care planning, following on from one of these processes | | |  |
| **Further details about the process:** | | | | | | |
| **2. What does the person find very difficult to do?** | | | | | |  |
| Understand information necessary to fully engage with care and support processes | |  | | Weigh up information as part of the process of being involved | |  |
| Retain information for long enough to be fully involved | |  | | Communicate their wishes and views | |  |
| **Further details about the difficulties the person will have in being involved:** | | | | | | |
| **3. Does the person have an appropriate individual to support them?** *(i) An appropriate individual can be anyone who is NOT*   * *someone providing care or treatment to the person in a professional capacity or on a paid basis* * *someone the person does not want to support them* * *someone who is unlikely to be able to, or available to, adequately support the person’s involvement* * *someone implicated in an enquiry into abuse or neglect or who has been judged by a safeguarding adult review to have failed to prevent abuse or neglect* | | | | | Yes  No  If **Yes**, then complete question 4. If **No,** then skip question 4. | |
| **4. People who have an appropriate individual to support them are not usually eligible for Care Act advocacy support. Please tell us why an advocate is still required**.  *(i) An advocate can still be involved if:*   * *the assessment or planning might result in a placement in NHS-funded provision; either in a hospital for more than 4 weeks, or in a care home for 8 weeks or more AND the local authority believes that arranging an advocate would be in the best interests of the person* * *the local authority and the friend or family member disagree on something relating to the person, but agree that it would benefit the person for them to have an advocate* | | | | | | |

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| **2. Details of the person you’re referring** | | | | | | | | | |
| **First name** |  | | | **Last name** |  | | | | |
| **Date of birth** |  | | | | | | | | |
| **Current address and postcode**  *(if hospital, please include ward name; if prison please include wing)* |  | | | | | | | | |
| **Home address and postcode** *(if different to current address)* |  | | | | | | | | |
| **Email** |  | | | | | | | | |
| **Phone number** |  | | | | | | | | |
| **What conditions or disabilities does the person you’re referring have?** *(Please select all that apply)* | | | | | | | | | |
| Learning disability | |  | | Sensory impairment | | | |  | |
| Acquired brain injury | |  | | Long term health condition | | | |  | |
| Autistic spectrum diagnosis | |  | | Substance misuse/addiction | | | |  | |
| Dementia | |  | | Physical disability | | | |  | |
| Neurological conditions | |  | | None | | | |  | |
| Stroke | |  | | Other *(please specify)*  Further details | | | | | |
| Mental health condition | |  | |
| **Is the person you are referring a carer?**  *(i) Informal carers (also called unpaid carers) are people who look after children and other family members, friends or neighbours because of physical or mental ill health or disability, or care needs related to old age, enabling them to continue to live as independently as possible at home and in the community.* | | | | | | Yes  No | | | |
| **Does the person have any access needs, for example communication or physical needs?** *(Please select all that apply)* | | | | | | | | | |
| They need an interpreter | | |  | They have physical access needs | | | | |  |
| They use Makaton | | |  | They do not use the telephone | | | | |  |
| They use British Sign Language (BSL) | | |  | They prefer information written down | | | | |  |
| They use assistive communication (e.g. Symbol book, Talking Mats, PECS) | | |  | Other *(please specify)* | | | | | |
| They are non-verbal | | |  | Further details | | | | | |
| They prefer information in Easy Read | | |  |  | | | | | |
| **Has the person you are referring requested an advocate?** | | | | Yes  No | | | | | |
| **If yes, do they require a same-gender advocate?**  *(i) We always try to meet same-gender requests but are not always able to do this, depending on availability.* | | | | | | Yes  No  Don’t know | | | |
| **Has the person agreed to this referral?**  *(i) If capacity fluctuates then they should be asked about agreeing to a referral when they have capacity* | | | | | | Yes  No  Lacks capacity | | | |
| **What meetings does the advocate need to attend?**  *(i) Please provide the title of the meeting and the date. You can add multiple meetings.*  **Names and dates of meetings** | | | | | | | | | |
| **Is there anything we need to know in order to ensure the safety of the person you are referring and of our advocates?** *(Please select all that apply)* | | | | | | | | | |
| 2 to 1 or higher support ratio | |  | | Other *(please specify)* | | |  | | |
| Daily change in risk profile | |  | | Further details | | | | | |
| History of abuse/​assault of professionals | |  | |
| **If your organisation has a reference number for the person, you must provide it here:**  *(i) For example, Mosaic, Care Direct, NHS or prison number* | | | |  | | | | | |
| ***For referrals to our Coventry and Warwickshire team only*** If you are referring someone who does not live in Coventry or Warwickshire but is registered at a GP surgery in Coventry or Warwickshire, please tick here:  Coventry GP  Warwickshire GP | | | | | | | | | |

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| Diversity monitoring | | | | |
| *We want to make sure that our services are reaching everyone who needs them. By giving us the information below about the person you’re referring, you can help us improve what we offer.* | | | | |
| What is the gender of the person you’re referring? | | | Is this different from their gender assigned at birth? | |
| Male |  | | Yes |  |
| Female |  | | No |  |
| Non-binary |  | | Don’t know/prefer not to say |  |
| Other |  | |  |  |
| Don’t know/prefer not to say |  | |  |  |
| What is their sexual orientation? | | | | |
| Heterosexual/​straight |  | | Gay woman/​lesbian |  |
| Bisexual |  | | Don’t know/​prefer not to say |  |
| Gay man |  | | They prefer to self-describe *(please specify)* |  |
| **What is their ethnic group?** | | | | |
| *Asian or Asian British* | | | | |
| Bangladeshi | |  | Pakistani |  |
| Chinese | |  | Another Asian background |  |
| Indian | |  | Don’t know/​prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | |
| African | |  | Another Black background |  |
| Caribbean | |  | Don’t know/​prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | |
| Asian and White | |  | Another Mixed background |  |
| Black African and White | |  | Don’t know/​prefer not to say |  |
| Black Caribbean and White | |  |  |  |
| *White* | | | | |
| British, English, Northern Irish, Scottish, or Welsh | |  | Another White background |  |
| Irish | |  | Don’t know/​prefer not to say |  |
| Irish Traveller or Gypsy | |  |  |  |
| *Another ethnic group* | | | | |
| Arab | | |  | |
| Another ethnic background | | |  | |
| Prefer not to say | | |  | |
| Don’t know/​prefer not to say | | |  |  |
| **What is their religion?** | | | | |
| No religion | |  | Christian (all denominations) |  |
| Buddhist | |  | Hindu |  |
| Jewish | |  | Muslim |  |
| Sikh | |  | Other (please state) | |
| Don’t know/​prefer not to say | |  |  | |

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| **3. Your details** | | | | | | |
| **Title** | |  | | | | |
| **Full name** | |  | | | | |
| **Email address** | |  | | | | |
| **Organisation** | |  | | | | |
| **Work address** | |  | | | | |
| **Team or department** | | *(If you work in Warwickshire, this must be completed with your full team name with code, e.g. LD North - AC514)* | | | | |
| **Profession** | | Doctor |  | Nurse | |  |
| Dentist |  | Other health professional | |  |
| Support worker |  | Social worker | |  |
| Lawyer |  | Manager | |  |
| Police |  | Other | | |
| **Job title (if different)** | |  | | | | |
| **Phone number we can contact you on if we have questions about this referral** | |  | | | | |
| **Mobile phone number (if different)** | |  | | | | |
| **Would you like to join our email newsletter?** | | Yes, please add my email to the mailing list  No, I’d prefer not to be added to the mailing list | | | | |
| **Is this the first time you have made a referral to VoiceAbility?** | | Yes  No | | | | |
| **If yes, please tell us how you heard about us.** *(Please select all that apply)* | | | | | | |
| Word of mouth |  | | Social media | |  | |
| Online search |  | | Presentation/​training | |  | |
| Leaflet or poster |  | |  | |  | |
| Other (please specify) |  | | | | | |

**Please email the completed form to** [**helpline@voiceability.org**](mailto:helpline@voiceability.org)**.**

If you are emailing this form from Warwickshire, Coventry or a Doncaster prison, you must email using an approved secure method. For more information, go to   
[**voiceability.org/about-advocacy/advocacy-referral-forms**](http://www.voiceability.org/about-advocacy/advocacy-referral-forms)

**Alternatively, you can post the form to VoiceAbility, c/​o Sayer Vincent, Invicta House, 108-114 Golden Lane, London, EC1Y 0TL**

For referrals from prisons, Health Care Representatives can hand this form in to the Head of Health Care, c/o Health Care Department.