**Kingston Advocacy Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Date of Referral** | | | | | |  | | | | | | | | **Client ID Number**  (Cambridge House use only) | | | | | | | | | | | | | | | | |
| **Client Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Name | | | | | |  | | | | | | | | Client DOB | | | | | | |  | | | | | | | | | |
| Home Address | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Address at point of referral (if different from above). If hospital please include ward name/number. | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode | | | | | |  | | | | | | | | Borough | | | | | | |  | | | | | | | | | |
| Telephone | | | | | |  | | | | | | | | Email | | | | | | |  | | | | | | | | | |
| **Type of Advocacy Required (please tick only one box per referral)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Care Act Advocacy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Independent Mental Capacity Advocacy (IMCA)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Generic Mental Health Advocacy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Generic Learning Disability Advocacy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Independent Mental Health Advocacy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **If IMCA please tick referral reason (Please only tick one box per referral)** | | | | | | | Serious Medical Treatment | | | | | | | | | | | | | | | | | | | | | | |  |
| Change of Residence | | | | | | | | | | | | | | | | | | | | | | |  |
| 28 Days in Hospital | | | | | | | | | | | | | | | | | | | | | | |  |
| Adult Protection | | | | | | | | | | | | | | | | | | | | | | |  |
| Care Review | | | | | | | | | | | | | | | | | | | | | | |  |
| **If Care Act please tick referral reason (Please only tick one box per referral)** | | | | | | | Needs Assessment | | | | | | | | | | | | | | | | | | | | | | |  |
| Preparation of Care And Support Plan | | | | | | | | | | | | | | | | | | | | | | |  |
| Safeguarding | | | | | | | | | | | | | | | | | | | | | | |  |
| Review of Care and Support Plan | | | | | | | | | | | | | | | | | | | | | | |  |
| Complaint/Appeal | | | | | | | | | | | | | | | | | | | | | | |  |
| If IMHA please tick the section that applies | | | | | | | Section 2 | | | | | | | | | | | | | | | | | | | | | | |  |
| Section 3 | | | | | | | | | | | | | | | | | | | | | | |  |
| Other: | | | | | | | | | | | | | | | | | | | | | | |  |
| **Details (please provide as much additional information as you can about the referral. Use additional sheets as necessary) if you are self-referring, please explain the issue you would like Advocacy support with.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **…………………**  **……………………….** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If client lacks capacity, please detail below who conducted the capacity assessment and where it can be located** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | |  | | | | | | | | | | | | Job Title | |  | | | | | | | | | | | | | | |
| Team | |  | | | | | | | | | | | | Department | |  | | | | | | | | | | | | | | |
| Borough | |  | | | | | | | | | | | | Address | |  | | | | | | | | | | | | | | |
| Telephone | |  | | | | | | | | | | | | Email | |  | | | | | | | | | | | | | | |
| Has a Capacity Assessment (as required by S.2 and S.3 of MCA 2005) been carried out? | | | | | | | | | | | | | | | | | Yes | | |  | | | | No | | |  | | | |
| If yes, where can it be located? | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **If client lacks capacity and a decision is being made in their best interest, please provide the details of the decision maker below** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Decision Maker | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Job Title | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Team | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Department | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Telephone | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Email | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Borough | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Other People Involved (insert new rows as necessary)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contact details of other relevant people (professionals, family or friends) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | Relationship to client | | | | | | | | Telephone | | | | | | | | | Email | | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | |
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| **If Client has capacity, please complete below** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the Client is aware of referral (if no please explain in additional information above) | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| Has the Client consented to the referral (if no please explain in additional information above) | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| **Client Need** (please enter x in relevant boxes) | | | | | | | | | | | **Mental Health Act Status** (please enter x in relevant box) | | | | | | | | | | | | | | | | | | | |
| Mental Health | | | | | | | |  | | | Is the client subject to the Mental Health Act? | | | | | | | | Yes | | |  | | | No | | | |  | |
| Learning Disability | | | | | | | |  | | |
| Dementia | | | | | | | |  | | | If yes, please indicate which section and why it is required | | | | | | | | | | | | | | | | | | | |
| Acquired Brian Injury | | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | | |
| Serious physical Illness | | | | | | | |  | | |
| Cognitive Impairment | | | | | | | |  | | |
| Other … |  | | | | | | | | | |
| **Ethnic Background** | | | |  | | | | | | | | | | | **Primary Means of Communication** (please enter x in relevant box) | | | | | | | | | | | | | | | |
| (please enter x in relevant box) | | | | | | | | | **M** | | | **F** | | |
| White British | | | | | | | | |  | | |  | | | English | | | | | | | | | | | | |  | | |
| White Irish | | | | | | | | |  | | |  | | |  | | | | | | | | | | | | |  | | |
| White Other | | | | | | | | |  | | |  | | | Other spoken language Please specify… | | | | | | | | | | | | |  | | |
| Mixed White & Black Caribbean | | | | | | | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| Mixed White & Black African | | | | | | | | |  | | |  | | | British Sign Language | | | | | | | | | | | | |  | | |
| Mixed White & Asian | | | | | | | | |  | | |  | | | Words | | | | | | | | | | | | |  | | |
| Other mixed | | | | | | | | |  | | |  | | | Pictures | | | | | | | | | | | | |  | | |
| Asian or Asian British Indian | | | | | | | | |  | | |  | | | Makaton | | | | | | | | | | | | |  | | |
| Asian or Asian British Pakistani | | | | | | | | |  | | |  | | | Gestures | | | | | | | | | | | | |  | | |
| Asian or Asian British Bangladeshi | | | | | | | | |  | | |  | | | Facial Expressions | | | | | | | | | | | | |  | | |
| Chinese | | | | | | | | |  | | |  | | | Vocalisations | | | | | | | | | | | | |  | | |
| Other Asian | | | | | | | | |  | | |  | | | No obvious means of Communication | | | | | | | | | | | | |  | | |
| Black or Black British Caribbean | | | | | | | | |  | | |  | | | *Comments* | | | | | | | | | | | | | | | |
| Black or Black British African | | | | | | | | |  | | |  | | |  | | | | | | | | | | | | | | | |
| Other | | | | | | | | |  | | |  | | |
| Withheld | | | | | | | | |  | | |  | | |
| **Please detail any risk issues or incidents the Advocacy service should be aware of:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name and details of person completing this referral form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | |  | | | | | | | | | | Email | | | | |  | | | | | | | | | | | | |
| Telephone No | | |  | | | | | | | | | | Relation to client | | | | |  | | | | | | | | | | | | |
| Job Title | | |  | | | | | | | | | | Date: | | | | |  | | | | | | | | | | | | |
| Please Return This Referral Form to  **imca@ch1889.org**  Or post it to us  **Cambridge House Advocacy**  **Unit F, Ground Floor, The Print Works, 22 Amelia Street London SE17 3PY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |