**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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **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**  |