**Barking and Dagenham Advocacy Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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)** | | | | | | | | | | | | | | | | | | | | | |
| **NHS Complaints Advocacy** | | | | | | | | | | | | | | | | | | | | |  |
| **Care Act Advocacy** | | | | | | | | | | | | | | | | | | | | |  |
| **Independent Mental Capacity Advocacy (IMCA)** | | | | | | | | | | | | | | | | | | | | |  |
| **Independent Mental Health Advocacy (IMHA)** | | | | | | | | | | | | | | | | | | | | |  |
| **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 IMHA please tick referral reason (Please only tick one box per referral)** | | | | Detained Under the Mental Health Act | | | | | | | | | | | | | | | | |  |
| Conditional Discharge | | | | | | | | | | | | | | | | |  |
| Subject to Guardianship | | | | | | | | | | | | | | | | |  |
| Community Treatment Order | | | | | | | | | | | | | | | | |  |
| Considered For Treatment To Which Section 57 Applies | | | | | | | | | | | | | | | | |  |
| **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 | | | | | | | | | | | | | | | | |  |
| **Details (please provide as much additional information as you can about the referral. Use additional sheets as necessary)** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **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 box/es) | | | | | | | **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**](mailto:imca@ch1889.org)  Or post it to us  **Advocacy at Cambridge House,**  **Unit F, Ground Floor,**  **The Print Works,**  **22 Amelia Street**  **London SE17 3PY** | | | | | | | | | |