**Independent Care Act Advocacy (ICAA) Referral Form**

**Advocacy and the duty to involve**

Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person’s needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

**When does the advocacy duty apply?**

The advocacy duty will apply from the point of first contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding review. If it appears to the authority that a person or their carer has care and support needs, then a judgement must be made as to whether that person has substantial difficulty in being involved. If they do, and there is not an appropriate individual to support them, an independent advocate must be appointed to support and represent the person for the purpose of assisting their full involvement.

**Please complete a SEPARATE referral PER REFERRAL REASON**

***If completing online, click once on relevant box to check. Write in text fields, where required.***

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| **Date of Referral:** | | | | | |
| **Professional Referrer’s Details** | | | | | |
| **Referrer First Name:** | | | | **Last Name:** | |
| **Organisation:** | | | | | |
| **Job Title or Relationship to Client:** | | | | | |
| Doctor | | Psychiatrist | | | Ward Manager |
| Care Manager | | Care Home Manager | | | Team Manager Health |
| Nurse / Health Professional | | Social Worker (Hospital) | | | Social Worker (Community) |
| Team Manager Social Care | | Administrator | | |  |
| Other / Non-Professional Relationship (specify) | | | | | |
| **Address:** |  | | | | |
| **Postcode:** | | | | | |
| **Tel No:** | | | **Mobile No:** | | |
| **Email:** | | | | | |

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| **Main Disability** Is there a **main** disability or impairment considered particularly relevant to this case? | | | | | |
| Check **ONE** box only | | | | | |
| Mental Health Condition  Physical Disability  Sensory (Hearing)  Sensory (Sight) | | Asperger’s /Autism Spectrum Condition  Cognitive Impairment  Acquired Brain Injury  Serious Physical Illness | | | Learning Disability  Dementia / Alzheimer’s  Unconsciousness  **NO** |
| **Client Information** | | | | | |
| **Title:**  Mr  Mrs  Ms  Other | | | **First Name:**  **Last Name:** | | |
| **Date of Birth:** | | | | | |
| **Permanent Address:** |  | | | | |
| **Postcode:** | | | | | |
| **Telephone No.** | | | | **Mobile No.** | |
| **E-mail** | | | | | |
| **Preferred method of contact:** | | | | | |
| Any  Telephone  E-mail  Post  Mobile Phone  Text  Cannot be contacted directly | | | | | |
| **Does the client consider themselves to have a disability?**  **Does the Client consider themself to have a disability?** | | | | | |
| Yes  No  Not known  Prefers not to say | | | | | |
| **What types of disability or impairment does the Client have?** Select **ALL** that apply | | | | | |
| Mental Health Condition  Acquired Brain Injury  Physical Disability  Serious Physical Illness  Sensory (Hearing)  Learning Disability  Sensory (Sight)  Dementia / Alzheimer’s  Asperger's / Autism Spectrum Condition  Unconsciousness  Cognitive Impairment  Other (specify) | | | | | |
| **What is the Client’s primary communication method?**  Spoken English  Other Spoken Language (specify)  British Sign Language (BSL)  Other (specify)  Words/Pictures/Makaton  No obvious means of communication  Gestures/Facial Expressions/Vocalisations Not known | | | | | |
| **Is English Spoken?**  Yes  No | | | | | |
| **Gender**  Male  Female  Transgender F to M  Transgender M to F  Prefers not to say  Other (specify) | | | | | |
| **Does the Client identify themself as Cornish?** Yes  No  Not known | | | | | |
| **Sexual Orientation** | | | | | |
| Lesbian  Gay Man  Heterosexual  Bisexual  Questioning  Not known  Prefers not to say Other (specify) | | | | | |

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| **Ethnic Background** | | |
| **White**  British  Irish  Gypsy or Irish Traveller  Any other White background (specify)    **Mixed Ethnic Groups**  White & Black Caribbean  White & Black African  White & Asian  Any other Mixed ethnic background (specify)    **Black / Black British**  African  Caribbean  Any other Black/African/Caribbean background (specify) | | **Asian / Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background (specify)    **Other Ethnic Group**  Arab  Any other ethnic group (specify)    Ethnicity not known  Prefers not to say |
| **Marital or Civil Partnership Status** |  | |
| Single  Separated (but still legally married / in civil partnership)  Co-habiting  Divorced or Civil Partnership Dissolved  Married  Widowed  In Civil Partnership  Surviving partner of Civil Partnership  Not known  Prefers not to say | | |
| **Religion or Belief** |  | |
| Buddhist  Christian (all denominations)  Hindu  Jewish  Muslim  Sikh  No Religion  Not known  Prefers not to say  Other (specify) | | |
| **Military Connection**  **oes the Client have a Military connection?** | | |
| Yes, Serving  Yes, Veteran  Yes, Carer relationship  No  Not known  Prefers not to say | | |

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| **Client Location Details** | |
| **Client’s current location:**  Own Home  Dementia Ward  Hospital  Own Home with Support  Care / Nursing home  Homeless  Supported Living  Prison  No Fixed Abode  Acute Psychiatric Unit  Forensic Secure Unit  Other Institution | |
| **Is Client currently at their permanent address?**  Yes  No (If No, give details below) | |
| **Current Address:** |  |
| **Postcode:** | |
| **Telephone No.** | |
| **Ward Name (if in Hospital):** | |

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| **ICAA Referral Details** | | |
| **Local Authority of Referrer:** | | |
| Referral Reason  (check **ONE** box only) | An adult needs assessment  A carer’s assessment  The preparation of a care and support plan or support plan  The review of a care and support plan  The review of a carer’s support plan  A child’s needs assessment under Transition to adult care/support  A child’s carer’s assessment under Transition to adult care/support  A young carer’s assessment  A safeguarding enquiry  A safeguarding adults review | |
| Does the person have Substantial Difficulty in:  (select **all** that apply) | understanding relevant information?  retaining information?  using or weighing up information?  communicating views, wishes and feelings? | |
| * Is the client subject to Mental Health Act section 117 Aftercare? | Yes  No  Don’t know | |
| Previous IMCA Involvement? | Yes  No  Don’t know | |
| Why does the person need an Independent Advocate? | Only paid professional help available  No friend/family member available  No preferred friend/family member available to them  No friend/family member available without a vested interest  Conflict/dispute with the Local Authority  Other (give details) | |
| Names and contact details of others involved or to be consulted |  |  |
| Please detail any risks or behaviours the Advocate needs to be aware of when dealing with the referral.  If you are not aware of any risks, please write 'no known risks' |  | |
| Describe the current circumstances of the client and explain what support is needed from the advocate. Please provide dates of any meetings already planned |  | |
| Are you aware of any records of the person’s wishes?  **If Yes**, please give details. | Yes  No | |

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| Emergency Contact Name: |
| Emergency Telephone Number: |
| Emergency Contact Relationship: |

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| Where appropriate, has the client been made aware of the referral? | Yes  No |
| Where appropriate, has the client given their consent to the referral? | Yes  No |
| Are you satisfied the referral meets the criteria under the Care Act? (and is in the best interests of the client if they have not been made aware or not given their consent) | Yes  No |

**Declaration:**

* I declare that I wish to instruct an Independent Care Act Advocate.
* I am providing this information and making this referral in relation to the Care Act 2014.
* In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
* I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

**Please e-mail the completed form to** [info@theadvocacypeople.org.uk](mailto:info@theadvocacypeople.org.uk)

or post to P.O. Box 375, Hastings TN34 9HU

If you have not received confirmation of this referral within 2 working days, or you would like to discuss any aspects of a referral, please call **0330 440 9000**

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service. For more information on our Privacy Policy, please ask your advocate or go to [www.theadvocacypeople.org.uk/privacy](http://www.theadvocacypeople.org.uk/privacy)

**Confidentiality:**

Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.