**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

 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.