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| **Community DoLS Advocacy Referral Form**  To help the person to understand their authorisation and how it affects them and  support them to exercise their rights.  Referrals are only accepted from Staffordshire and Stoke City Council Adult Social  Care Team. |  |

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| 1. **Eligibility.** | | | | | | | | | | | |
| **The person being referred must be:**   1. *Over 16.* 2. *Assessed as lacking capacity.* 3. *Not free to leave their place of care.* 4. *Requiring supervision and control in their best interests.* | | | | | | | | | | | |
| 1. **About the person requiring support.** | | | | | | | | | | | |
| **Mr/ Mrs:** | | **Name:** | | | | | | | | **Date of birth:** | |
| **Tel:** | | **Email:** | | | | | | | | **Mobile:** | |
| **Current Address:**  **Postcode:** | | | | | | | | | | | |
| Own Home: | | | Care Home: | | | | Hospital: | | | Other: | |
| **Social References:** (P numbers, LAS, etc) | | | | | | | | | | | |
| 1. **How does this person communicate?** | | | | | | | | | | | |
| Preferred Language: | | | | | | | Dialect: | | | | |
| Spoken Language | | | | | |  | Gestures/Facial Expressions/Vocalisations | | | |  |
| British Sign Language | | | | | |  | Words/ Pictures/ Makaton | | | |  |
| Not known | | | | | |  | Other, please give details: | | | | |
| **Known Risks (to themselves or others):** | | | | | | | | | | | |
| 1. **What are the person’s additional support needs?** | | | | | | | | | | | |
| Mental Health problems | | | | |  | | Physical Health | | | |  |
| Cognitive Impairment | | | | |  | | Autism Spectrum Condition | | | |  |
| Learning Disability | | | | |  | | Serious Physical Illness | | | |  |
| Other | | | | |  | | Please specify: | | | | |
| 1. **Who is the referral for?** | | | | | | | | | | | |
| An adult with care and support needs |  | | | A carer with support needs | | | |  | A parent of a child open to Children’s Social Care | |  |
| 1. **Type of process.** | | | | | | | | | | | |
| Witness Statement | | | | | | | On-Going representation by CoP | | | | |
| 1. **When making referrals please provide proposed Care Plans and Assessments relating to the deprivation.** | | | | | | | | | | | |
| Please list attached documents for this referral or provide quotations here. | | | | | | | | | | | |
| 1. **Nature of Substantial Difficulty (please tick all that apply).** | | | | | | | | | | | |
| Understanding relevant information | | | | |  | | Retaining information | | | |  |
| Using or weighing up information | | | | |  | | Communicating their views, wishes and feelings | | | |  |
| 1. asist main logo 2010**Please confirm that there is no one appropriate OR available to facilitate the persons active involvement.** | | | | | | | | | | | |
| I confirm there is no one appropriate or available to facilitate involvement: | | | | | | | | | | | |
| 1. **Additional Information.** | | | | | | | | | | | |
| **Brief summary of situation and reason for requesting an Advocate.**  Please provide any additional background information which will help the Advocate to support the person being referred.  What steps need to be taken to maximise the person’s full participation (For example, consideration of mental capacity, sensory needs, autism related needs and confidence.  This could also include interpreters, appropriate adult, family members, information and advice, communication aid, appropriate time of day/effects of medication, suitable environment). | | | | | | | | | | | |
| **Please give details of any forthcoming meeting dates.**  Please provide dates/location/ time/ in person or via Teams. Are other professionals in attendance? What is the meeting for? | | | | | | | | | | | |

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| 1. **Diversity Monitoring.** | | | | | |
| **By completing the information below you can help us ensure our services reach everyone who needs them and inform how we might improve our service provision.** | | | | | |
| **What is the person’s gender?** | | | | **Is the person’s gender different from that assigned at birth?** | |
| Male | | |  | Yes |  |
| Female | | |  | No |  |
| Non-binary | | |  | Don’t know/prefer not to say |  |
| Don’t know/prefer not to say | | |  |  |  |
| Person’s own description: | | | |  |  |
| **What is the person’s sexual orientation?** | | | | | |
| Heterosexual/straight | | |  | Gay woman/lesbian |  |
| Bisexual | | |  | Don’t know/prefer not to say |  |
| Gay man | | |  | Person’s own description: | |
| **What is the person’s ethnic group?** | | | | | |
| *Asian or Asian British* | | | | | |
| Bangladeshi | | |  | Pakistani |  |
| Chinese | | |  | Another Asian background |  |
| Indian | | |  | Don’t know/prefer not to say |  |
| *Black, African, Black British or Caribbean* | | | | | |
| African | | |  | Another black background |  |
| Caribbean | | |  | Don’t know/prefer not to say |  |
| *Mixed or multiple ethnic groups* | | | | | |
| Asian and White | | |  | Another Mixed background |  |
| Black African and White | | |  | Don’t know/prefer not to say |  |
| Black Caribbean and White | | |  |  |  |
| *White* | | | | | |
| English/Welsh/Scottish/Northern Irish/British | | |  | Another White background |  |
| Irish | | |  | Don’t know/prefer not to say |  |
| Irish Traveller or Gypsy | | |  |  |  |
| *Another ethnic group* | | | | | |
| Arab | | |  | Don’t know/prefer not to say |  |
| Another ethnic background | | |  | Person’s own description: | |
| **What is the person’s religion?** | | | | | |
| No religion | | |  | Hindu |  |
| Christian (all denominations) | | |  | Muslim |  |
| Buddhist | | |  | Other (please state) |  |
| Jewish | | |  | Don’t know/prefer not to say |  |
| Sikh | | |  | Person’s own description: | |
| **Does the person identify as having a disability or long-term health condition?** | | | | | |
| Yes | No | Please specify: | | | |

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| 1. **Referrer Contact Details.** | |
| Name of referrer: | Job Title: |
| Team: | Organisation: |
| Email: | Tel |
| Date of Referral: | How did you hear about us: |

**To be completed by Children and Young Peoples Services only**

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| 1. **Adult Social Care (ASC) Assessor Details.** | | | |
| Are or will ASC be involved? | | | |
| Name of ASC Social Worker/ Assessor: | | | |
| Team (if known): | | | |
| Telephone Number: | Email address: | | |
| 1. **Consent.** | | | |
| Have you discussed this referral with the person being referred? (where appropriate) | | Yes | No |
| Has the person agreed to this referral being made? | | Yes | No |
| **Disclaimer** | | | |
| **Please note that we may not be able to attend all meetings listed on the referral form. Where possible, provide us with 2 weeks-notice for any meetings to allow the advocate adequate time to support the advocacy partner.** | | | |
| **The referrer is responsible for providing ASIST with accurate, up to date information and contact details, and updating ASIST with any new information or, amendments to information provided on the referral form after it has been submitted. PLEASE make sure information is correct before submitting this form.** | | | |
| **To discuss a referral please contact Asist on 01782 845584**  **Fill in this form and send to Asist by emailing** [referrals@asist.co.uk](mailto:referrals@asist.co.uk)  **Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW.** | | | | |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

