**Independent Health Complaints Advocacy Referral Form.**

To provide guidance, empower and support people who wish to make a complaint about the service they have received from the NHS, whether directly provided or commissioned by the NHS.

Referrals can be made by anyone.

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| 1. **Eligibility.** | | | | | | | | | | | | | |
| **The person must be:**   1. *Resident in Stoke-on-Trent or Staffordshire and be living within these areas.* | | | | | | | | | | | | | |
| 1. **Details of the person making the complaint (Complainant).** | | | | | | | | | | | | | |
| **Mrs/Mr:** | **Name:** | | | | | | | | | | **Date of Birth:** | | |
| **Tel:** | **Email:** | | | | | | | | | | **Mobile:** | | |
| **Current Address:**  **Postcode:** | | | | | | | | | | | | | |
| 1. **Details of the patient (if different from above).** | | | | | | | | | | | | | |
| **Mrs/Mr:** | **Name:** | | | | | | | | | **Date of Birth:** | | | |
| **Tel:** | **Email:** | | | | | | | | | **Mobile:** | | | |
| **Current Address:**  **Postcode:** | | | | | | | | | | | | | |
| 1. **How does this person communicate?** | | | | | | | | | | | | | |
| Preferred Language: | | |  | | | Dialect: | | | | | | | |
| Spoken Language | | |  | | |  | Words/Pictures/Makaton | | | | | |  |
| British Sign Language | | |  | | |  | Gestures/Facial Expressions / Vocalisation | | | | | |  |
| Not Known | | |  | | |  | Other, please give details: | | | | | | |
| **Additional Support Needs:** (dyslexia, large print, colour blindness, etc. | | | | | | | | | | | | | |
| **Known Risks (to themselves and others)** (pets, parking, smoking, allergies, covid positive, etc) | | | | | | | | | | | | | |
| **Can we leave this person messages?** | | | | | | | | | **If yes, how?** | | | | |
| 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. **Your Complaint is about: Please Tick all that apply and include organisation names.** | | | | | | | | | | | | | |
| Name of Hospital(s) | | | |  | | | | West Midlands Ambulance Service | | | |  | |
| Name of the GP Practice | | | |  | | | | SDUC out of hours GPs | | | |  | |
| Mental Health Services Combined  Healthcare NHS Trust | | | |  | | | | Community Health & Health Centre | | | |  | |
| Inclusive of GP, doctors, administrators, receptionists, mental health professionals, out of hours staff, physiotherapists, pharmacies, etc | | | | | | | | | | | | | |
| 1. **Issue being complained about (please tick all that apply).** | | | | | | | | | | | | | |
| Attitude of staff | | Waiting Times | | | | | | | | Care and Treatment | | | |
| Other: | | | | | | | | | | | | | |
| **Meeting Dates: Please give details of any forthcoming meeting dates.** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 1. **Other Comments:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 1. **Date of Incident:** | | | | | | | | | | | | | |
| Please give details about when the incident occurred/ you first became aware there was an issue: | | | | | | | | | | | | | |
| 1. **Incident.** | | | | | | | | | | | | | |
| **Please give a summary account of the incident.**  Please include the Names of the organisation/ location/ people involved/ dates/ times/ outcomes wanted. If you are complaining about multiple instances, please list each one separately. | | | | | | | | | | | | | |
| 1. **Additional Information.** | | | | | | | | | | | | | |
| Have you already contacted someone about this issue? Or already submitted a complaint? Have you or the person contacted the organisation you are complaining about? Please provide any additional information you believe is relevant. | | | | | | | | | | | | | |

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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/your gender?** | | | | **Is the person’s/your 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/your 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/your 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/your 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/you identify as having a disability or long-term health condition?** | | | | | |
| Yes | No | Please specify: | | | |

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| 1. **Referrer Contact.** | | |
| Self-Referred: | Family/ Friend Referred: | |
| 1. **Referrer Contact Details (if you are making a referral for someone else).** | | |
| Referrer’s Name: | Job Title: | |
| Team: | Organisation: | |
| Email: | Tel: | |
| Date of referral: | How did you hear about us: | |
| 1. **Consent.** | | |  |
| **The person being referred consents to the 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.** | | |  |

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| **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)

