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| **Spot Purchasing Advocacy Referral Form** For ASIST to be able to provide paid advocacy support for those living within Staffordshire and Stoke-on-Trent who do not qualify for free advocacy provision.Referrals accepted from health and social care teams. |  |

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| 1. **Eligibility.**
 |
| **The person must:**1. *Be 18+.*
2. *Have a learning, sensory or physical disability and/or a mental health need.*
 |
| 1. **The person requiring support.**
 |
| **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/ Vocalisations | [ ]  |
| Other, please give details:       |
| **Known risks (to themselves or others):** Please include if the person is currently Covid positive any historical risks, environmental factors, etc       |
| 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:       |
| 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 Advocacy process (Please only pick one process per referral form).**
 |
| DoLS/RPR | [ ]  | Care Act | [ ]  | Parental | [ ]  |
| CHC Assessment | [ ]  | Health Issues | [ ]  | BAME | [ ]  |
| 1. **What process does the person require support with? (Please tick one per referral form).**
 |
| Assessment | [ ]  | Care & Support Planning | [ ]  | Review | [ ]  |
| Safeguarding Enquiry | [ ]  | Safeguarding Adult Review | [ ]  | Complaints | [ ]  |
| Child In Need | [ ]  | Child Protection | [ ]  | PLO/ Care Proceedings | [ ]  |
| Health issues | [ ]  | DoLS/RPR | [ ]  | Cultural issues | [ ]  |
| Legal issues | [ ]  | Activities | [ ]  | Other:       |
| 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 that there is no one appropriate or available to facilitate involvement: | [ ]  |
| 1. **How does this person communicate?**
 |
| Preferred Language:       | Dialect:       |
| Spoken Language | [ ]  | Gestures/Facial Expressions/Vocalisations | [ ]  |
| British Sign Language | [ ]  | Words/Pictures/Makaton | [ ]  |
| Other, please specify:       |
| 1. **Additional Information.**
 |
| **Brief summary of situation and reason for requesting an Advocate.**  Please provide any additional background information.  What steps need to be taken to maximise the person’s full participation?      |
| **Please give details of any meeting dates/process.** Please include any dates/ times/ locations (virtual, in person, office based or at the persons home address), meeting duration, issue or meeting, etc      |
| **Please provide any further information you believe is relevant to the referral.** Are there other professionals involved with this referral?       |

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| 1. **Diversity Monitoring.**
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| **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* |
| Bangaldeshi  | **[ ]**  | 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       |
| 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. **Managers Authorisation.**
 |
| Team Managers Name:       | Organisation:       |
| Email address:       | Telephone Number:       |
| Team Managers Signature *(electronic):*       | Date:       |
| 1. **Consent.**
 |
| Have you discussed this referral with the person being referred?  | Yes [ ]  | No [ ]  |
| Has the person agreed to this referral being made?  | Yes [ ]  | No [ ]  |
| **Disclaimer** |
| ***Please note that in some cases, multiple advocates may support the advocacy partner (you will be informed of this). Once the case is allocated, an advocate will be in contact to discuss the case and their availability.***  |
| **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.**  |
| **Upon receipt of a referral, we will process it and issue you with our case reference number. The referral will then be reviewed to check eligibility and availability of our advocates. ASIST will make contact to confirm invoicing information and completion of our authorisation form. This *must* be completed before the case can be allocated to an advocate and before any work can proceed.**  |
| **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****Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW.** |

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

