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| **Care Act Advocacy Referral Form**    To provide independent advocacy to facilitate the involvement of a person in their  assessment, preparation of a care plan, in safeguarding enquiries and Safeguarding  Adults Reviews.  Referrals only accepted from Staffordshire and Stoke City Council Adult Social Care  Team. |

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| 1. **Eligibility.** | | | | | | | | | | |
| **The person must:**   1. *Be registered as a Staffordshire or Stoke-on-Trent City Council resident.* 2. *Have ‘substantial difficulty’ being fully involved in the Care Act assessment.* 3. *Have no ‘appropriate person’ (unpaid) to facilitate and represent their wishes.*   **An advocate may be engaged if the above conditions are not met, but only in the following instances:**   1. *Where the outcome of an assessment may result in a person being placed in an NHS funded establishment for a period exceeding four weeks, or in a care home for a period of eight weeks or more and the council believe it would be in the best interests of the person to arrange for an advocate.* 2. *Where the council and the appropriate person disagree about who is best placed to support the person and they agree that involving an advocate would be beneficial.* 3. *Where a person who is not resident in Staffordshire or Stoke-on-Trent has been referred within Staffordshire or Stoke-on-Trent to adult safeguarding.* | | | | | | | | | | |
| 1. **About the person requiring support.** | | | | | | | | | | |
| **Mrs/ Mr:** | | **Name:** | | | | | **Date of birth:** | | | |
| **Tel:** | | **Email:** | | | | | **Mobile:** | | | |
| **Current Address:     .**  **Postcode:** | | | | | | | | | | |
| Own Home | Care Home | | | | Hospital | | | | Other | |
| Social Services Liquid Logic Number/ other reference: | | | | | | | | | | |
| A carer with support needs | | | |  | An adult with care and support needs | | | | |  |
| Does the Person have capacity to make decisions regarding this referral? | | | | | | | | Yes | | No |
| I confirm the person has no-one APPROPRIATE or available to facilitate involvement | | | | | | | | | |  |
| 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):** Currently on a Covid positive ward, any historical risks, 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. **What is the Nature of the person’s Substantial Difficulty? (Please tick all that apply)** | | | | | | | | | | |
| Understand relevant information | | | |  | Retaining information | | | | |  |
| Using or weighing up information | | | |  | Communicating views, wishes & feelings | | | | |  |
| 1. **What process does the person require support with? (Please tick)** | | | | | | | | | | |
| Adult needs assessment | | | Care and Support Planning | | | Review of care and support plan | | | | |
| Transition needs assessment | | | Carers assessment | | | Review of carers support plan | | | | |
| Safeguarding Enquiry | | | | | Safeguarding Adults Review | | | | | |
| 1. **Additional Information.** | | | | | | | | | | |
| **Please give details of any forthcoming meeting dates and a brief explanation about the requested support.**  Please include any locations and times already confirmed, and if they are in person or via Teams/ Zoom. | | | | | | | | | | |
| **What steps need to be taken to maximise the person’s full participation? e.g., consideration of:**  Mental capacity, sensory needs, autism related needs and confidence, interpreters, information and advice or communication aid, appropriate time of day/effects of medication, suitable environment, physical and or mental health needs, etc… | | | | | | | | | | |
| **Please provide any further information relevant to this referral.**  Are there other professionals involved in the referral/ providing other support? | | | | | | | | | | |

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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. **Local Authority Referrer Contact Details.** | | | |
| Name of referrer: | Job title: | | |
| Team: | Organisation: | | |
| Email: | Tel: | | |
| Date of Referral: | How did you hear about us: | | |
| 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 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)

