**Independent Advocacy under the Care Act (St Helens)**

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| **Full name:** |  |
| **DOB:** |  |
| **Permanent address:** |  |
| **Current location if different from permanent address:** |  |
| **Telephone number:** |  |
| **Mobile number:** |  |
| **Email address:** |  |
| **Disability or impairment:** | Learning disability  Acquired brain injury  Autistic spectrum disorder  Dementia  Neurological conditions  Stroke  Mental health condition  Sensory impairment  Long term health condition  Physical disability  None  Not listed, **please specify:**  Prefer not to say |
| **Gender:** | Female  Male  Non-binary  Not listed, **please specify:**  Prefer not to say |
| **Pronouns:** | He/him  She/her  They/them |
| **Sexual orientation:** | Bisexual  Heterosexual  Lesbian or gay  Not listed, **please specify:**  Prefer not to say |
| **How does the person communicate?** | English  Other spoken language, **please specify:**  British Sign Language  Words/pictures/Makaton  Gestures/expressions/vocalisations  Not listed, **please specify:**  No obvious means of communication |
| **Ethnic origin:** | Arab/British Arab  Asian/British Asian  Black/Black British  Gypsy/Roma/Traveller  Mixed heritage  White British – English, Welsh, Scottish, N. Irish  White – Irish  White Other  Not listed, **please specify:**  Prefer not to say |
| **Religion or belief:** | Atheist  Baha’i  Buddhist  Christian  Hindu  Humanist  Jewish  Muslim  Pagan  Not listed, **please specify:**  Prefer not to say  No religion or belief |
| **Have you or any of your family served in the armed forces?** | Yes  No |

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| **Social Worker’s contact details:** | |
| Name: | Role: |
| Address: | |
| Email | |
| Telephone number: | Fax: |

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| **Issue to be addressed:** | | |
| Assessment, review or care and support planning: | CHC assessment: | Safeguarding (Section 42 enquiry or safeguarding adult review): |
| Please provide further information below: | | |

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| **Substantial difficulty:** | | | |
| I have reasonable belief that the person will have substantial difficulty with the process at this time but may become able again in the near future |  | I have reasonable belief that the person will have substantial difficulty with the process and will do for the foreseeable future |  |

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| **Has a capacity assessment been carried out?** | Yes | No |
| Outcome of the capacity assessment: | | |

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| **Family and friend involvement:** |
| Does the person have an appropriate adult willing and able to facilitate their involvement in the process/processes and does the individual consent to their involvement?  If not, please provide further details: |

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| **Significant dates:** |
| Please provide details for any impending meetings or deadlines: |

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| **Further relevant information:** |
| Please provide details: |

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| **Consent:** | | |
| Due to GDPR (2018), we need signed authorisation to say that people agree to Advocacy Focus holding personal information (including the information on this referral)  If the person being referred is deemed to lack capacity, the referrer must sign to say they are referring and providing information in the person’s best interests, acknowledging that the person referred lacks capacity to make this decision. | | |
| **Does the person have capacity to consent to the referral?** | Yes | No |
| **If yes, has consent been obtained?** | Yes | No |

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| **Please provide details of any risk the Independent Advocate will need to consider:** |
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| **I would like an Independent Advocate to support me in accordance with the Care Act 2014:** | |
| Person’s signature: | Date: |

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| **I would like an Independent Advocate to do this work in accordance with the Care Act 2014:** | |
| Referrer’s signature: | Date: |

**Please email the completed form to: admin@advocacyfocus.org.uk**