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| **Hartlepool Adult Social Care Advocacy**  **Care Act Referral Form**  **October 2023** | | | | |
| **GUIDANCE:** | | | | |
| **Not providing the necessary information could affect response times.**  **Please complete the form in full, including signatures and dates.**  ***NB we accept referrals directly by email to***  [**adultscommissioning@hartlepool.gov.uk**](mailto:adultscommissioning@hartlepool.gov.uk) | | | | |
| Discuss this referral to Adult Social Care Advocacy with the patient/individual for HBC to identify a Care Act Advocate from the Provider Framework.  Give the patient/individual the opportunity to decide whether to request advocacy  support themselves. Consider referring to Advocacy if you think the patient/individual may benefit from advocacy support, but is unable, or unlikely to request support themselves. A referral should **NOT** be made to Advocacy where the referrer knows, or strongly suspects the patient / individual does not want the support of an Advocate. Advocacy is not a substitute for any independent advocacy which already takes place.  *This form is subject to review to maintain service provision and monitoring.* | | | | |
| **PLEASE RETURN THE COMPLETED FORM VIA EMAIL** | | | | |
| **SERVICE USER DETAILS:** | | | | |
| **Name:** |  | | | |
| **Gender:** |  | | **DOB: Age:** | |
| **Permanent Address:** |  | | | |
| **Postcode:** |  | | **Telephone:** | |
| **Current Location:** |  | | | |
| **Postcode:** |  | | **Telephone:** | |
| **ETHNIC BACKGROUND *(Please tick box that applies)*** | | | | |
| **White British** | |  | **Black/Black British (African)** |  |
| **White Irish** | |  | **Black/Black British (Caribbean)** |  |
| **White (Other Background)** | |  | **Black/Black British (Other Background)** |  |
| **Mixed: White/Black African** | |  | **Asian/Asian British (Bangladeshi)** |  |
| **Mixed: White/Black Caribbean** | |  | **Asian/Asian British (Indian)** |  |
| **Mixed: White/Asian** | |  | **Asian/ Asian British (Pakistani)** |  |
| **Mixed:(Other Background)** | |  | **Asian/Asian British (Other Background)** |  |
| **Chinese** | |  | **Other Ethnic Group** |  |
| **Any identified religious, cultural or spiritual needs?** | | | | |
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| **Are there any relevant risks that the Advocate should be aware of? (eg: behavioral, security issues, exposure to infection). If yes please give brief details.** | | | | | | |
|  | | | | | | |
| **REFERRAL DETAILS:** | | | | | | |
| **IS** | **THIS A** | **SELF-REFERRAL?** | |  | YES | NO |
| The advocacy service has a duty to ensure the safety of lone workers. In accordance with General Data Protection Regulations 2018 we reserve the right to speak to and request information from third parties regarding past and current risk. For further  information please contact the advocacy service. | | | | | | |
| **IF THIS IS NOT A SELF-REFERRAL PLEASE PROVIDE DETAILS BELOW:** | | | | | | |
| **Referrer:** | | |  | | | |
| **Role:** | | |  | | | |
| **Address:** | | |  | | | |
| **Postcode:** | | |  | **Telephone:** |  | |
| **Email:** | | |  | **Fax:** |  | |
| **REASON FOR REFERRAL** | | | | | | |
|  | | | | | | |
| **BRIEF DETAILS OF THE SITUATION THAT REQUIRES ADVOCACY INVOLVEMENT**: | | | | | | |
|  | | | | | | |
| **Eligibility:** Does the person have substantial difficulty in being fully involved in Local Authority processes?  Yes/No  **Please give more information about their substantial difficulties, including any communication difficulties and reasonable adjustments you have already made for them**  **Support**  **Are there any other professionals or family** / **carers involved with the person?**  **Yes/ No**  **Name: Job Title**  **Contact Details:** | | | | | | |

# There is no-one appropriate available to support and represent their wishes Yes/No Care group:

|  |  |
| --- | --- |
| Mental Health | Yes/ No |
| Learning Disability | Yes/ No |
| Autism · | Yes/ No |
| Older People | Yes/ No |
| Physical Disability including Sensory Impairment | Yes/ No |
| Substance Misuse | Yes/ No |
| Carers (including Young Carers) | Yes/ No |
| Young People aged 16-18 in Transition to Adult Services | Yes/ No |
| Other (please give more information) | Yes/ No |

**What issue(s) does the person need advocacy support for?**

|  |  |
| --- | --- |
| Accessing HBC Adult Services information and advice | Yes/ No |
| A needs assessment | Yes/ No |
| A carers assessment | Yes/ No |
| Care planning | Yes/ No |
| Review of a careplan | Yes/ No |
| A child's needs assessment | Yes/ No |
| Safeguarding enquiry / review | Yes/ No |

Please note that if your referral involves a possible change of accommodation it may be that the decision maker (usually a social worker or health caseworker) has a legal duty to offer Independent Mental Capacity Advocacy (IMCA) as well as Care Act Advocacy in which case the hub will request additional referral information / referral from you.

# Please give more information about the issues that the person needs advocacy support for:

*(please indicate)*

Has the patient/ individual received Advocacy support before? **YES/NO/DON'T KNOW**

If yes, name of Advocate/ Provider:

**ARE THERE ANY DEADLINES OR IMPORTANT MEETING DATES?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONTACT DETAILS:** | | | | |
| **Care Coordinator:** |  | | | |
| **Address:** |  | | | |
| **Postcode:** |  | | **Telephone:** |  |
| **Email:** |  | | **Fax:** |  |
| **GP:** |  | | | |
| **Address:** |  | | | |
| **Postcode:** |  | | **Telephone:** |  |
| **Email:** |  | | **Fax:** |  |
| **Nearest Relative:** |  | | | |
| **Address:** |  | | | |
| **Postcode:** |  | | **Telephone:** |  |
| **Email:** |  | | **Fax:** |  |
| **DECLARATION:** | | | | |
| Because of the General Data Protection Regulations 2018 a signature is needed to say that you agree to HBC securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of HBC that all personal data will be held in accordance with the principles and requirements of the General Data Protection Regulations 2018 and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. You can request further information on confidentiality from ourselves, or the appropriate advocacy service.  *I agree that HBC Advocacy service can securely hold, and put on computer and in a filing system, the information on this form.*  **MUST BE SIGNED AND DATED** | | | | |
| SIGNATURE | |  | | |
| DATE | |  | | |
| **THE REFERRER** (leave blank if signed by Service User) I would like HBC to do this work. They can keep, and put on computer and in a filing system, the information on this form provided to do the work. I am providing this information and asking for this referral in the Service User's best interests.  **MUST BE SIGNED AND DATED**. | | | | |
| SIGNATURE | |  | | |
| PRINT NAME | |  | | |
| DATE | |  | | |