**Care Act Referral Form**

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| **Client Details** | |
| **Date of Referral:** |  |
| **Name:** |  |
| **Current Address:** |  |
| **Home Address (if different)** |  |
| **Home / Mobile Number(s):** |  |
| **Ward Contact Number(s):** |  |
| **Email:** |  |
| **DOB:** |  |
| **Age** | 18 to 25  26 to 35  36 to 45  46 to 55  56 to 65  66 to 74  75+  Prefer not to say |
| **Communication Requirements:** | British Sign Language  Non - verbal  Spoken English  Gestures / Facial Expressions / Vocalisations  Pictures / Symbols / Makaton  Requires information written down  Prefers Easy Read  Requires an Interpreter  Other – Please describe: |
| **Physical Accessibility Requirements:** | Please describe: |
| **Individuals condition, impairment or disability:** | Mental Health Condition  Physical Disability  Acquired Brain Injury  Learning Disability  Autistic Spectrum Diagnosis  Stroke  Cognitive Impairment  Sensory Impairment  Long term health condition  Dementia  Substance misuse/addiction  Unconsciousness  Neurological Conditions  None  Other - Please describe: |
| **Gender:** | Female  Male Prefer not to say  Prefers to self-describe, please say how:  Is their gender identity different from the one they were assigned at birth?  Yes  No  Prefer not to say |
| **Ethnicity:** | **Asian or Asian British**  Asian British  Bangladeshi  Chinese  Indian  Pakistani  Another Asian background, please describe:  **Black, African, Caribbean, or Black British**  African  Black British  Caribbean  Another Black, African or Caribbean background, please describe:  **Mixed or Multiple ethnic groups**  Asian and White  Black African and White  Another Mixed or Multiple Black Caribbean and White ethnic groups, please describe:  **White**  Gypsy or Irish Traveller  English  Irish  Northern Irish  Scottish  Welsh  Another White background,  Other European  please describe:  **Another ethnic group**  Arab  Another ethnic group, please describe:  Prefer not to say |
| **Sexual Orientation:** | Asexual Bisexual Gay  Heterosexual  Lesbian Pansexual Questioning Prefer to self-describe, please say how:  Prefer not to say |
| **Religion or Belief:** | Buddhist  Christian  Hindu  Jewish  Muslim  Sikh  No religion  Prefer not to say  Another religion or belief, please say which: |

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| Area of Support Required *(Please Only Mark One):* | |
| A needs assessment under Section 9 |  |
| A carer’s assessment under Section 10 |  |
| Preparation of a care and support plan or support plan under Section 25 |  |
| A review of a care and support plan or support plan under Section 27 |  |
| A safeguarding enquiry or Safeguarding Adult Review |  |

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| **Consent** | | |
| 1. Has the individual consented to the referral? (If **yes**, continue to the next section - Area of Support Required) | **Yes** | **No** |
| 1. If consent has not been given, has this individual been assessed as lacking capacity? | **Yes** | **No** |
| 1. If **Yes** are you giving us instruction in line with the Mental Capacity Act? | **Yes** | **No** |
| What was the date of the capacity assessment? | **Date:** | |
| If you have answered **No** to question 2 & 3, then we are unable to proceed with the referral: please call us on 01332 299 449 Option 2 to discuss this further. | | |

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| **Eligibility Criteria** | | |
| 1. Has the Individual been assessed by the referrer as having **substantial difficulty** to engage in an assessment/safeguarding process? | **Yes** | **No** |
| 1. Has the Individual been supported with Information and Advice around the assessment/safeguarding process? | **Yes** | **No** |
| 1. Has the Individual been deemed by the referrer as having no **appropriate person** to support them to engage in an assessment/safeguarding process? | **Yes** | **No** |
| If there are persons involved with the Individual, but the referrer has deemed them not to be appropriate, please detail whom and why: | | |
| If you have answered **No** to any of these questions, then we are unable to proceed with the referral: please call us on 01332 299 449 Option 2 to discuss this further. | | |

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| **Please state what stage the individual is at in the required area of support; this will help us triage the case quickly (Please Only Mark One):** | |
| Beginning of process |  |
| Pre-assessment |  |
| Post assessment |  |

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| **Reason for Care Act Advocacy Referral** |
| What is the issue that the individual requires support with? Please provide as much detail as possible. |

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| **Risk Management** |
| Are there any potential risks for the advocate providing support? or any potential risks for the individual receiving support from an advocate? |

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| **Referrer Details** | |
| Full Name: |  |
| Job Title: |  |
| Team/Organisation: |  |
| Address: |  |
| Telephone: |  |
| Email: |  |
| Relationship to client: |  |
| **By signing this document, you are instructing Disability Direct Advocacy to do this work, and you are authorised by the NHS Body/Local Authority responsible for making this decision.** | |
| Signature: |  |
| Date: |  |

Please send the completed referral form to:

Email: [advocacy@disabilitydirect.com](mailto:advocacy@disabilitydirect.com)

Post: DDA, 20 Royal Scot Road, Pride Park, Derby, DE24 8AJ

If you have any questions or concerns, please give us a call on 01332 299 449 - Option 2