one advocacy

Care Act Referral Form

Date Received:	

Client ID:	

Consent

Has Client consented to the referral?	**Yes**		**No**	
Note:				
If no, have they been made aware of referral? If not, why?	**Yes**		**No**	
Note:				
If the client is not able to consent, are you giving us instruction?	**Yes**		**No**	
Note:				

Client Details

Client Name:		Date of Birth:	
Current Address:			
Home Address: (if different)			
Contact Number(s):			

Gender

Male:		Female:		Prefer Not to Say:	

Ethnicity

White British		Black Caribbean		Mixed Caribbean		Indian		Mixed White	
Irish		Black African		Mixed African		Pakistani		Other Asian	
White Other		Black Other		White/Asian		Bangladeshi		Chinese	
Prefer Not to Say									

How does the person communicate?

Spoken English		Another Spoken Language		Gestures/Facial Expression/Vocalisations	
BSL		No Obvious Communication		Pictures/Symbols/Makaton	

Nature of client's impairment (mark all that apply)

Unconsciousness		Mental Health Problems		Acquired Brain Damage		Learning Disability	
Autism Spectrum		Serious Physical Illness		Dementia		Cognitive Impairment	
Other: (give details)							

Is this advocacy under the Care Act? If **Yes** please complete the following boxes, if **No** please go to **Reason for Specialist Advocacy Referral**	**Yes**		**No**	
Has the **client** been **assessed by referrer** as having **substantial difficulty** to engage in assessment/safeguarding process?	**Yes**		**No**	
Has the client been **deemed by referrer** as having **no appropriate person** to support them to engage in assessment/safeguarding process?	**Yes**		**No**	
If there are persons involved with the client but referrer has deemed them not appropriate, please detail whom and why:				
Has the **client** been **supported** with **Information and Advice** around the assessment/safeguarding process?	**Yes**		**No**	

Stage the client is at in the required area of support; this will help us triage the case more rapidly ***(Please Mark Only One):***

Stage:	
Beginning of process	
Pre-assessment	

Post assessment	

Area of Support Required *(Please Mark Only 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	

Reason for referral

What is the issue the client wants advocacy support for? Please provide as much detail as you can:

Please detail any risk issues or incidents one advocacy and our staff should be aware of:

Details of person completing this form

Name:	
Job Title:	
Team/Organisation:	
Address:	
Telephone:	
Email:	

Signed: **Date:**

Name (please print):		**Relationship to client:**	

Send completed form to:

one advocacy
Sinfin Library
Arleston Lane
Derby
DE24 3DS or;

email to **referrals@oneadvocacyderby.org**

For further information visit **www.citizensadvicemidmercia.org.uk**

or call the **Direct Referral line 01332 228748**

Online: www.citizensadvicemidmercia.org.uk

Postal address: one advocacy, Sinfin Library, Arleston Lane, Sinfin, Derby DE24 3DS
Telephone support & triage: 01332 228748

Clients: OAclients@citizensadvicemidmercia.org.uk
Professionals: referrals@oneadvocacyderby.org

Hours of business: Mon – Fri 9 a.m. – 5 p.m.

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