Clients being referred to this service must be aged 18 or over and be residents of Essex, must be accessing Social Care or be at risk of needing Social Care access. Community advocacy supports people in making difficult and / or important decisions which may impact on their quality of life and independence and may have long term consequences. We cannot support with everyday decisions or provide ongoing support

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Details | | | | | | | | |
| Name |  | | | Known as | |  | | |
| Date of birth |  | | | Gender | |  | | |
| GP Surgery the client is registered with |  | | | | GP Surgery contact number | | |  |
| Address of current location |  | | | | | | | |
| postcode |  | | | Telephone no. | |  | | |
| Staff contact name at current address | |  | | | | | | |
| Home address (if different from above) |  | | | | | | | |
| postcode |  | | | Telephone no. | |  | | |
| Religion or spiritual beliefs |  | | | | | | | |
| Ethnicity | White British | | White Irish | | | | White Gypsy / Irish Traveller | |
| Other White background | | Black / Black British African | | | | Black / Black British Caribbean | |
| Other Black background | | Asian / Asian British Bangladeshi | | | | Asian / Asian British Chinese | |
| Asian / Asian British Indian | | Asian / Asian British Pakistani | | | | Other Asian background | |
| White / Asian | | White / Black African | | | | White / Black Caribbean | |
| Other mixed background: | | Other ethnic group: | | | | | |
| Additional needs | Learning Disability | | Mental Illness | | | | Dementia | |
| Autism | | Acquired Brain Injury | | | | Other: | |
| Communication needs / preferences | English language | | Other spoken language: | | | | British Sign Language | |
| Pictures / symbols | | Makaton | | | | Gestures / facial expressions | |
| Sounds / vocalisations | | No formal means of communication | | | | Other: | |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Details | | | |
| Name (or self - referral) |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  | | |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Who should we contact to arrange initial appointment? |  |
| Signature |  | | |
| Print name |  | Date referral made |  |
| Is the client aware of the referral?  NOTE: If a referral is made without the permission of any patient who has the capacity to consent to advocacy; this breach of that patient’s confidentiality will be reported to the referring body’s Information Governance team in all cases. | | | Yes / No |
| If ‘no’, why is the client not aware of the referral? | | | |
| Does the client lack the capacity to consent to a referral? If so, the Responsible Clinician must have consented to the referral. This consent will allow the service to process the client’s information, act on behalf of the client, create anonymised case studies and share anonymised case notes for advocacy qualification training purposes | | | Yes / No |

|  |  |  |  |
| --- | --- | --- | --- |
| Responsible Clinician, Care Co-ordinator or Support Worker Details | | | |
| Name |  | Job Title |  |
| Organisation / Service |  | Team |  |
| Address |  | | |
| Postcode |  | Telephone / mobile number |  |
| Email address |  | Secretary (if applicable) |  |
| Signature |  | | |
| Print name |  | Date |  |

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| About the Referral | | | | |
| Is the client subject to the MHA? | Yes / No | If ‘yes’, do they have an IMHA? | | Yes / No |
| The client must be 18 years old or above and meet at least one of the following criteria to access the service. **Please tick all which apply** | | | | |
| Diagnosed with a long-term condition | | | |  |
| Older person (65 or above) | | | |  |
| LD and / or autism | | | |  |
| Physical disability | | | |  |
| Carer | | | |  |
| Has identified care and support needs | | | |  |
| Accessing substance misuse support / treatment | | | |  |
| Accessing mental health support / treatment | | | |  |
| Please provide a brief explanation for the advocacy referral | | | | |
| Are there any family or friends who could help? | | | Details: | |
| Are there upcoming meetings / deadline dates that we need to be aware of? | | | | |
| Are there current risks we need to be aware of? | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| For Community Advocacy service use | | | |
| Date referral received |  | Advocate assigned to case |  |
| RIS number |  | Person processing referral |  |

Email this form to: [essexadvocacy@rethink.org](mailto:essexadvocacy@rethink.org)

Send by post to: Rethink Advocacy, Saxon House, 27 Duke Street, Chelmsford, CM1 1HT

Telephone: 0300 790 0559

**General Data Protection Regulation (GDPR)** All records are kept in accordance with current GDPR legislation

For concerns or complaints regarding the referral please contact

Contract Manager: Audrey Haggis [audrey.haggis@rethink.org](mailto:audrey.haggis@rethink.org)