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| **Please note all fields must be completed or the form will be returned: this could delay an Advocate being allocated. Where Not Applicable please indicate by inserting N/A** |
| **You may be eligible for this service if you are resident in the local authority area and wish to make a complaint about a service commissioned or provided by the NHS. Priority will be given to people with physical or sensory disability, long term health conditions, mental health/learning disability, conditions on the autistic spectrum, older people including those with mental health needs or are informal carers of these groups.** |
| **Date of Referral** |
| **Client Details** |
| Client Name |  | Client DOB |  |
| Home Address |  |
| **Address at point of referral** (if different from above). If hospital, please include ward name/number |  |
| Post code |  | Local Authority/Borough |  |
| Telephone |  | Email |  |
| GP Surgery the client is registered with  |  | GP Surgery contact number |  |
| Details - please provide **brief** details about the complaint |
|  |
| Please give a brief explanation of the need for advocacy including why advocacy support is needed if there is other support available |
|  |
| Are there upcoming meetings or dates that we need to be aware of? |
|  |
| We usually meet people in community venues in the community we may agree to carry out home visits but only in exceptional circumstances, please let us know if there any risks we should be aware of if we carry out a home visit?  |
|  |
| If you are completing this form on behalf of someone else you must have their permission to do so, if you do not you could be breaking the law. By signing below you are confirming that you have sought consent from the complainant to request advocacy. |
| Is the person aware of and consented to the referral for advocacy support? | Yes/No  |
| If no, does the client lack capacity to consent to a referral? | Yes/No |
|  |
| **Name and details of person completing this referral form** |
| **Name** |  | **Job Title** |  |
| **Telephone No** |  | **Email** |  |
| **Relationship to client** |  | **Date** |  |
| If you completing this form on behalf of the person who requires advocacy you must have their permission to do so, if you do not, you could be breaking the law. By signing the referrers signature box above, you are confirming that you have sought consent to request advocacy, and you are confirming the person wants advocacy support. |
| **Additional information – Please tick those that apply** |

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| **Religion or spiritual belief** |
| Buddhist |  | Jewish |  | Other Religion |  |
| Christian |  | Muslim |  | No Religious Belief |  |
| Hindu |  | Sikh |  | Do not wish to answer |  |
| **Ethnicity** |
| Asian or Asian British - Any Other Asian Background |  | Mixed - Any other mixed background |  | White - Any Other White Background |  |
| Asian or Asian British - Bangladeshi |  | Mixed - White and Asian |  | White - British |  |
| Asian or Asian British - Indian |  | Mixed - White and Black African |  | White - Gypsy or Irish Traveller |  |
| Asian or Asian British - Pakistani |  | Mixed - White and Black Caribbean |  | White - Irish |  |
| Black or Black British - African |  | Do not wish to answer |  | Not provided |  |
| Black or Black British - Caribbean |  | Other Ethnic Group - Any other ethnic group |  | Do not wish to answer |  |
| Black or Black British - Other Black Background |  | Other Ethnic Group - Arab |  |  |
| **Sexual orientation** |
| Heterosexual / Straight |  | Bisexual |  | Not Provided |  |
| Homosexual / Gay Man |  | Other |  |  |
| Lesbian / Gay Woman |  | Do not wish to answer  |  |  |
| **Additional needs** |
| Learning Disability |  | Mental Illness |  | Dementia |  |
| Autism |  | Acquired Brain Injury |  | Other |  |
| **Communication needs / preferences** |
| Preferred language (please specify) |  | English language |  | Other spoken language (please specify) |  |
| Preferred method of communication (please specify) |  | Able to read |  | British Sign Language |  |
| Pictures / symbols |  | Makaton |  | Gestures / facial expressions |  |
| Sounds / vocalisations |  | No formal means of communication |  | Other support needs |  |
| Hearing impairment |  |  |
| **Other** |

|  |  |  |  |
| --- | --- | --- | --- |
| Gender |  | Identifies as same sex as at birth | Yes/No/Prefers not to answer |
| Marital status |  |

|  |
| --- |
| Pregnant /maternity Yes/No |
| Mental health diagnosis: |
| **Please return this referral to:**essexadvocacy@rethink.org0300 790 0559 |