If you have read the Rethink NHS complaint self-help pack and feel you need an advocate to support you with an NHS complaint please complete this referral form.

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| **Details of the person making the complaint**  |
| Name |  | Known as |   |
| Date of birth |  | Gender |  |
| Address of current location |  |
| postcode |  | Telephone no. |  |
| Home address (if different from above) |  |
| postcode |  | Telephone no. |  |
| Email Address |  |
| 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: |

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| About the Referral |
| The complainant must have an identified advocacy need in order to access this service (for example poor communication skills, mental illness, LD etc). **Please provide details below** |
|  |
| Are there family, friends or other services who could help? | Details:  |
| Please provide a brief explanation for the advocacy referral, including why advocacy support is needed if there is other support available |
| Name of the person the complaint relates to |  |
| NHS provider the complaint is about (e.g. hospital / dentist etc) |  |
| When did the treatment / incident happen? |  |
| Please provide brief details of the complaint |  |
| Are there upcoming meetings / deadline dates that we need to be aware of? |
| Are there current risks we need to be aware of? |

|  |  |
| --- | --- |
| **Is the person this complaint is regarding aware of this referral?** | **Yes / No** |
| **If ‘no’, why are they not aware of the referral?** |
| **NOTE: If a referral is made without the permission of any person who has the capacity to consent to advocacy; this breach of that person’s confidentiality will be reported to the referring body’s Information Governance team in all cases.** |

|  |  |
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| **Does the person this complaint relates to lack the capacity to consent to a referral?**  | Yes / No |
| **NOTE: where you identify that the client lacks capacity to consent to the referral, you are providing the necessary consent by submitting this form. 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 or commissioning reports.** |
| Signature of complainant |  |
| Print name |  | Date referral made |  |
| Signature of who the complaint relates to |  |
| Print name |  | Date referral made |  |

Email this form to: 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