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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A picture containing clipart  Description automatically generated** | | | | | **Advocacy Service  Referral Form** | | | | | | | | | | | | | | | | | | | | | |
| * Please **tick** the box to indicate if this is a Care Act, IMCA or IMHA referral *(one referral per form).* * **Select** your local authority from the list * Fill out **Section 1: General Information** * Proceed to the corresponding section of this form  (**Section 2 Care Act, Section 3: IMCA, Section 4: IMHA**) * Complete **Section 5;** **Equality and Diversity Monitoring** Read and sign **Section 6: Data Protection and Signature** | | | | | | | | | | | | | | | | | | | | | |
| Please ensure you **complete this form fully**, including the equalities information Section 5. If the form is not fully completed, this may delay the appointment of an advocate | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you need help or have questions, please contact our office on **0191 478 6472** or freephone **0800 048 7856** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Text field boxes will expand as you type** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Care Act** | | | |  | | **IMCA** | | | | | | | | | |  | | | | | **IMHA** |  | | | | |
| **Select the appropriate Local Authority for the referral:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | - Select - | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 1: General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.1 About the person** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Reference number for the person** *(i.e. Mosaic, Care Direct, NHS):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **First name:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Last name:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Preferred pronouns** *(i.e. She, He, They):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Date of birth** *(DD/MM/YYYY):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Home address:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Postcode:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Address at time of referral** *(if different to above & including ward if relevant):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Postcode:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Person’s contact information** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Mobile: | | | | | | | | | |  | | | | | | Landline: | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Can we Text? - Select - | | | | | | | | | | |  | | | | | | Leave voicemails? - Select - | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Send email? Yes | | | | | | | | | | | |  | | | | | Email: | | | | | | | |  |
|  | **Is the person being discharged from hospital?** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | | | | |  | | | | | Discharge date: | | | | | | | |  |
| **1.2 Accessibility information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Preferred Language:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | | | | |  | | | | | Other: | | | | | | | |  |
|  | **Communication and Access needs** *(please tick all that apply):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Able to read | | | | | | |  | | | | | | Hearing impaired | | | | | | | | | |  | |  |
|  | Braille | | | | | | |  | | | | | | Large print | | | | | | | | | |  | |  |
|  | British Sign Language | | | | | | |  | | | | | | Manual alphabet | | | | | | | | | |  | |  |
|  | Easy Read | | | | | | |  | | | | | | Minicom | | | | | | | | | |  | |  |
|  | English is a second language (ESL) | | | | | | |  | | | | | | Moon | | | | | | | | | |  | |  |
|  | Gestures/expressions/vocalisations | | | | | | |  | | | | | | No formal means of communication | | | | | | | | | |  | |  |
|  | Pictures/Symbols/Makaton | | | | | | |  | | | | | | Other: | | | | | | | | | | | |  |
|  | **Support from interpreting services** *(i.e. spoken language, BSL):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Requires a same gender advocate:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | *(we will always try to meet same-gender requests but are not always able to do this, depending on availably)* | | | | | | | | | | | | | | | | | | | | | | |  |
| **1.3 Referrer details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Full name:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Organisation:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Work address:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Team or department:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Contact information** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Mobile: | | | | | | | | | | |  | | | | | | Landline: | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Email: | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Profession** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Social worker | | | | | |  | | | | | | | Dentist | | | | | | | | | |  | |  |
| Doctor | | | | | |  | | | | | | | Other health professional | | | | | | | | | |  | |
| Nurse | | | | | |  | | | | | | | CHC case worker | | | | | | | | | |  | |
|  | Not listed, please specify: | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Job title** *(if different to above):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Would you like to join our email newsletter?** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Yes, please add my email to the mailing list | | | | | | | | | | | | | | | |  | |  | No, thanks | | |  | | |  |
|  | **Is this the first time you have made a referral to Your Voice Counts Advocacy?** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | - Select - | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **Please tell us how you heard about us** *(Please tick all that apply):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Word of mouth | | | | | | | |  | | | | | Online search | | | | | | | | | |  | |  |
|  | Leaflet of poster | | | | | | | |  | | | | | Social media | | | | | | | | | |  | |  |
|  | Awareness raising/training provided by Your Voice Counts | | | | | | | | | | | | | | | | | | | | | | |  | |  |
|  | Not listed, please specify: | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **1.3 Key people** *(include relationship and contact information):* | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **1.4 Risk** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Please tell us about any risk issues or incidents relevant to the person we should be aware of** *(tick all that apply, you must tick at least one box):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | No risk identified | | | | | | | | |  | | | | | Risk of harm due to medication/medical condition | | | | | | | | |  | |  |
|  | Risk of deliberate self-harm | | | | | | | | |  | | | | | Risk of suicide | | | | | | | | |  | |  |
|  | Risk of severe self-neglect | | | | | | | | |  | | | | | Risk of domestic violence/abuse | | | | | | | | |  | |  |
|  | Risk of adult abuse | | | | | | | | |  | | | | | Risk of violence/harm to others | | | | | | | | |  | |  |
|  | Risk to a child | | | | | | | | |  | | | | | Risk to staff | | | | | | | | |  | |  |
|  | Risk of exploitation | | | | | | | | |  | | | | | Risk of radicalisation | | | | | | | | |  | |  |
|  | **Please provide details of any known risks that professionals need to be aware:** | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **1.5 Other** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Timescales and key dates** *(i.e. date of upcoming meetings):* | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Section 2: Care Act** | | | | | | |
| **Eligibility criteria check list**  For a person to be eligible for a Care Act Advocate, **ALL THREE** of the following must apply:   1. The person is going through one of the processes listed in the first question below 2. Without support, the person will have substantial difficulty in being involved in a decision. 3. The person does not have any appropriate, able and willing family or friends to support their active involved.   An **appropriate individual** can be anyone who is not:   * someone providing care or treatment to the person in a professional capacity or on a paid basis * someone the person does not want to support them   People who have an **appropriate individual** to support them are not usually eligible for Care Act Advocacy support. Please tell us why an advocate is still required.  A Care Act Advocate can still be involved if:   * the assessment or planning might result in a placement in NHS funded-provision; either in a hospital for more than 4 weeks, or in a care home for more than 8 weeks or more AND the local authority believes that arranging an advocate would be in the best interests of the person * the local authority and the friend or family member disagree on something relating to the person, but agree that it wodul benefit the person for them to have an advocate   Your Voice Counts accepts referrals for individuals that are 18 years old and over, with the exception of individuals 15+ that are transitioning from Children’s Services to Adult Services.  In line with the Care Act 2014, referrals will only be accepted from the Local Authority or NHS. | | | | | | |
| **2.1 Care Act details** | | | | | | |
|  | **Which Care Act process is taking place?** | | | | |  |
|  | - Select - | | | | |  |
|  | **Describe the current situation:** | | | | |  |
|  |  | | | | |  |
|  | **What does the person find very difficult to do?** *(tick all that apply)* | | | | |  |
|  | Understand the information necessary to fully engage with care and support processes |  | Weigh up information as part of the process of being involved | |  |  |
|  | Retain information for long enough to be fully involved |  | Communicate their wishes and views | |  |  |
|  | **Does the person have someone appropriate and willing to support them?** | | | | |  |
|  | - Select - | | | | |  |
|  | **Is the person you are referring a carer?** *(an informal carer, also called unpaid carer)* | | | | |  |
|  | - Select - | | | | |  |
|  | **Has the person you are referring requested an advocate?** | | | | |  |
|  | - Select - | | | | |  |
|  | **Has the person agreed to this referral?** | | | | |  |
|  | - Select - | | | | |  |
|  | **If the person lacks capacity, please confirm you are referring in their best interests?** | | | | |  |
|  | - Select - | | |  | |  |
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| **Section 3: Independent Mental Capacity Advocate (IMCA)** | | | | | | | | |
| **Eligibility criteria check list**   * An IMCA referral **must** be made for decisions about long term accommodation and serious medical treatment * An IMCA referral **may** be made for care review following a long-term accommodation decision, or for safeguarding issues * IMCAs do not offer support for financial issues. These may need to be referred to the Court of Protection.   We ask referrers before making a referral:   * to identify if the person has previously named someone who could help with the decision and if that person may be available and willing to help * to identify if the person has appointed an attorney under a Lasting/Enduring Power of Attorney who continues to manage the person’s affairs   Please provide information where unpaid persons are available (e.g. family or friends) but they are **considered ‘inappropriate to consult’**, about why they are considered inappropriate to consult.  Are you the **decision maker**?   * For serious medical treatments, the decision maker can be a GP, dentist, doctor or consultant * For long term accommodation, the decision maker can be a social worker, care coordinator, discharge coordinator or nurse   If you do not know who the decision maker is we can process the referral without knowing, but you will need to tell us **before the advocate can start work**. | | | | | | | | |
| **3.1 IMCA details** | | | | | | | | |
|  | **What is the best interest decision?** | | | | | | |  |
|  | - Select - | | | | | | |  |
|  | **For changes of accommodation what are the proposed arrangements:** | | | | | | |  |
|  | Arrangements for the provision of or change in accommodation is proposed by an NHS Body |  | | The move to residential accommodation/care home is for a period likely to exceed 8 weeks | | |  |  |
| Arrangements for the provision of or change in accommodation is proposed by a Local Authority |  | | The move to hospital is likely to be for a period exceeding 28 days | | |  |
|  | **For care reviews please confirm which of the following applies:** | | | | | | |  |
|  | Accommodation in a care home, hospital or residential accommodation has been providing to the person for a continuous period of 12 weeks or more by an NHS Body | | | | | |  |  |
| Accommodation in a care home, hospital or residential accommodation has been providing to the person for a continuous period of 12 weeks or more by a Local Authority | | | | | |  |
|  | **Please describe the decision in detail:** | | | | | | |  |
|  |  | | | | | | |  |
|  | **When is the deadline for the decision?** | | | | | | |  |
|  |  | | | | | | |  |
|  | **Meeting dates and times:** | | | | | | |  |
|  |  | | | | | | |  |
|  | **Are you the decision maker?** | | | | | | |  |
|  | - Select - | | | | | | |  |
|  | **Name of the decision maker if this is not you:** | | | | | | |  |
|  |  | | | | | | |  |
|  | **Decision maker contact information:** | | | | | | |  |
|  | Mobile: | |  | | Landline: | | |  |
|  |  | | | | | | |  |
|  | Email; | | | | | | |  |
|  | **People with knowledge of the person / situation** *(include relationship and contact information):* | | | | | | |  |
|  |  | | | | | | |  |
|  |  | | | | | | |  |
|  | **Does the person have capacity to make the decision you are referring about?** | | | | | | |  |
|  | - Select - | | | | | | |  |
|  | **Has a 2-stage functional assessment of capacity been carried out?** | | | | | | |  |
|  | - Select - | | | | | | |  |
|  | **Date of capacity assessment?** | | | | | | |  |
|  |  | | | | |  | |  |
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| **Section 4: Independent Mental Health Advocate (IMHA)** | | | | |
| **Eligibility criteria check list**  IMHAs are available to anyone detained under the Mental Health Act (even on leave of absence from the hospital). **EXCEPT** people under certain short-term sections: 4, 5, 135 and 136.  We need to know the date a person has been sectioned as we may need to respond within a certain timeframe.  Individuals subject to the Mental Health Act are entitled to an IMHA, you can self-refer yourself. Please contact our Central Support Team if you would like to make a self-referral for IMHA support.  Mental health staff have a **duty** to ensure everyone eligible can access IMHA services. | | | | |
| **4.1 IMHA details** | | | | |
|  | **Section:** | | |  |
|  | Which section: - Select - |  | Date of Section: |  |
|  | **Responsible clinician:** | | |  |
|  | **Name:** |  | **Email:** |  |
|  | **Care Co-ordinator:** | | |  |
|  | **Name:** |  | **Email:** |  |
|  | **Has the person you are referring requested an advocate?** | | |  |
|  | - Select - | | |  |
|  | **Has the person agreed to this referral?** | | |  |
|  | - Select - | | |  |
|  | **If the person lacks capacity, are you referring in best interests?** | | |  |
|  | - Select - | | |  |
|  | **Is this a self-referral?** | | |  |
|  | - Select - | | |  |
|  |  | | |  |

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| **Section 5: Equality and Diversity** | | | | | |
| We collect the information in this section to help us shape our services to represent the needs of our communities. This information is known as **‘equality monitoring data’** and helps us to create equality of access and opportunity and helps us to improve the services that we provide.  We will keep this information confidential and will only use it anonymously.  If you are referring someone please discuss how they describe themselves and complete. | | | | | |
|  | **Disability or impairment** *(please tick all that apply):* | | | |  |
|  | Learning disability |  | Sensory |  |  |
|  | Autism |  | Stroke |  |  |
|  | Mental health |  | Cancer |  |  |
|  | Drug/alcohol misuse |  | Heart condition |  |  |
|  | Elderly/frail |  | No long-term health condition |  |  |
|  | Alzheimer’s/Dementia |  | Other physical illness or disability |  |  |
|  | Other describe: | | | |  |
|  | **Gender:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  |  | | | |  |
|  | **Sexual orientation:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  | **Ethnic origin:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  |  | | | |  |
|  | **Religion or belief:** | | | |  |
|  | - Select - | Other describe: | | |  |
|  | | | | | |

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| **Section 6: Data Protection** | | |
| **General Data Protection Regulations**  **Statement:** Your Voice Counts is committed to processing information in accordance with the General Data Protection Regulations (GDPR). The personal data collected on this form will be held securely and will only be used for the purposes of providing independent advocacy. We will hold the data for 6 years.  You can use the below contact details if you have any questions about this form, the way we are planning to use the information on the form, the lawful basis for processing the information on the form, or any queries relating to data protection.  **Contact details:**  Jenny Rohde (Head of Operations) [jenny.rohde@yvc.org.uk](mailto:jenny.rohde@yvc.org.uk) | | |
|  | **Signature of person making the referral:** |  |
|  |
| **Date of referral:** |
|  |
|  |
| If you need support to complete this form you can get in touch by phone, email, or through our website.  Our office **0191 478 6472** or freephone **0800 048 7856**  **Please email the completed form to** [**yvc.uk@nhs.net**](mailto:yvc.uk@nhs.net)  Alternatively, you can post the form to Your Voice Counts, Greensefield Business Centre, Mulgrave Terrace, Gateshead, NE8 1PQ  **We will contact you within 2 working days of receipt of your referral**  Logo  Description automatically generated | | |