**Independent Advocacy Referral Form**

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| **Care Act Advocacy and the duty to involve**  Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person’s needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.  **When does the advocacy duty apply?**  The advocacy duty will apply from a person’s point of first contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding review. If it appears to the authority that a person or their carer has care and support needs, then a judgement must be made as to whether that person has **substantial difficulty** in being involved. If they do, is there an **appropriate person that they are in agreement** to support them? An **independent advocate** must be appointed to support and represent the person for the purpose of assisting their involvement if these two conditions are met. Please refer to our guidance notes for further information.  **Independent Issue based advocacy ( not meeting Care Act criteria)**  Advocacy which does not meet the criteria for Care Act will be considered and where possible advocacy support will be provided. Please be aware that Care Act Advocacy must take precedence because of its statutory nature; if you would like to discuss this further then please contact **Devon Link Up on 07808053992 referralsdlup@gmail.com** | | | | |
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| **Client / Patient Details** | |  | | |
| **Title, first name and surname** |  | | |
| **Preferred first name** |  | | |
| **Home address** |  | | |
| **Postcode** |  | | |
| **District Council** |  | | |
| **Contact number**  **Mobile number** |  | | |
| **Email** |  | | |
| **Preferred method of contact** |  | | |
| **Primary means of communication** | English  Other spoken language  British Sign Language  Words / pictures / Makaton | | Gestures / Facial expressions / vocalisations  No obvious means of communication  Other (please state) |
| **Emergency contact** |  | | |
| **Emergency telephone number** |  | | |
| **Emergency contact relationship** |  | | |
| **Please state any known risks which the advocate should be aware of.** |  | | |

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| **Client Monitoring Information** | |
| **Gender** | Male  Female |
| **Ethnic Background** | Asian or Asian British Bangladeshi  Asian or Asian British Chinese  Asian or Asian British Indian  Asian or Asian British Pakistani  Other Asian or Asian British  Black or Black British African  Black or Black British Caribbean  Other Black or Black British  White British  White Gypsy / Traveller  White Irish  White Other |
| **Date of Birth** |  |
| **Disability/Vulnerability** |  |
| **Referral Details** | |
| **Referral Date** |  |
| **Referral Reason** | Care Act Advocacy  A needs assessment  A carer’s assessment  The preparation of a care and support plan or support  plan  A review of care and support plan or support plan  Safeguarding (enquiry or review) – If there are ‘Protective measures’ to be considered, and the person does not have Mental Capacity then an IMCA should be instructed.  **Non Care Act Advocacy** – Please give a brief outline of the issue |
| **Current Location**  **Location address details:** | Own home  Care / nursing home (name)  Hospital (name)  Supported living (name)  Prison (name)  Other (please state): |
| **Substantial Difficulty** | The person is unable to:  Understand relevant information  Retain information  Use or weigh information  Communicate views, wishes and feelings |
| **Has the person previously been in receipt of advocacy services?** | Yes  No  N/A  If yes, please provide details: |
| **Has the person previously received support from the IMCA service?** | Yes  No  N/A  If yes, what was the decision to be made? |
| **Why does the person need an**  **Independent Advocate?** | Only paid professional help available  No friend/family member available  No preferred friend/family member available to them  No friend/family member available without a conflict of interest  Other reason, please give details |
| **Referrer name** |  |
| **Referrer job title or relationship** |  |
| **Referrer contact numbers** |  |
| **Referrers email** |  |
| **Referrers profession** |  |
| **Names and contact details of others involved or to be consulted** |  |
| **Referrers signature and date** |  |

**COMPLETED FORM should be emailed to**: [dac@seap.org.uk](mailto:dac@seap.org.uk)

**or posted to:**

SEAP

PO BOX 375

HASTINGS

TN34 9HU

**Any queries please call 0300 343 5707 or email** [**dac@seap.org.uk**](mailto:dac@seap.org.uk)

**Data Protection**

All records are kept in accordance with current Data Protection legislation

**Alternatively please contact**

Devon Link Up

The Beehive

Dowell Street Honiton

EX14 1LZ

[referralsdlup@gmail.com](mailto:referralsdlup@gmail.com)