Hartlepool Advocacy Hub
Care Act Referral Form April 2021

GUIDANCE:

Not providing the necessary information could affect response times. Please complete the form in full, including signatures and dates. *NB we are able to accept referrals directly. by.'Anycomms' or email to* advocacyhub@incontrol-able.co.uk

Discuss this referral to the Advocacy Hub with the patient/individual for the Advocacy Hub to identify a Care Act Advocate from the Provider Framework.
Give the patient/individual the opportunity to decide whether to request advocacy support themselves.Consider referring to the Advocacy Hub if you think the patient/individual may benefit from advocacy support, but is unable, or unlikely to request support themselves.A referral should **NOT** be made to the Advocacy Hub where the referrer knows, or strongly suspects the patient / individual does not want the support of an Advocate. The Advocacy Hub is not a substitute for any independent advocacy which already takes place.*This form is subject to review to maintain service provision and monitoring.*

PLEASE RETURN THE COMPLETED FORM VIA EMAIL (Preferably) OR TO:
Hartlepool Advocacy Hub, c/o Incontrol-able CIC, Dimensional House, 81 Stranton, Hartlepool TS24 7QT**. Landline: 01429 555 009 Mobile: 07522 866 080**

SERVICE USER DETAILS:

Name:			
Gender:		**DOB:**	**Age**
Permanent Address:			
Postcode:		**Telephone:**	
Current Location:			
Postcode:		**Telephone:**	

ETHNIC BACKGROUND *(Please tick box that applies)*

White British		**Black/Black British (African)**	
White Irish		**Black/Black British (Caribbean)**	
White (Other Background)		**Black/Black British (Other Background)**	
Mixed: White/Black African		**Asian/Asian British (Bangladeshi)**	
Mixed: White/Black Caribbean		**Asian/Asian British (Indian)**	
Mixed: White/Asian		**Asian/ Asian British (Pakistani)**	
Mixed: (Other Background)		**Asian/Asian British (Other Background)**	
Chinese		**Other Ethnic Group**	

Any identified religious, cultural or spiritual needs?

Are there any relevant risks that the Advocate should be aware of? (eg: behavioral, security issues, exposure to infection). If yes please give brief details.

REFERRAL DETAILS:

IS THIS A SELF-REFERRAL? YES NO

The advocacy service has a duty to ensure the safety of lone workers. In accordance with General Data Protection Regulations 2018 we reserve the right to speak to and request information from third parties regarding past and current risk. For further information please contact the advocacy service.

IF THIS IS NOT A SELF-REFERRAL PLEASE PROVIDE DETAILS BELOW:

Referrer:			
Role:			
Address:			
Postcode:		**Telephone:**	
Email:		**Fax:**	

REASON FOR REFERRAL

BRIEF DETAILS OF THE SITUATION THAT REQUIRES ADVOCACY INVOLVEMENT:

Eligibility: Does the person have substantial difficulty in being fully involved in Local Authority processes?
Yes/No
Please give more information about their substantial difficulties, including any communication difficulties and reasonable adjustments you have already made for them

Support
Are there any other professionals or family / carers involved with the person?
Yes/ No

Name: **Job Title**

Contact Details:

There is no-one appropriate available to support and represent their wishes Yes/No

Care group:

Mental Health	Yes/ No
Learning Disability	Yes/ No
Autism	Yes/ No
Older People	Yes/ No
Physical Disability including Sensory Impairment	Yes/ No
Substance Misuse	Yes/ No
Carers (including Young Carers)	Yes/ No
Young People aged 16-18 in Transition to Adult Services	Yes/ No
Other (please give more information)	Yes/ No

What issue(s) does the person need advocacy support for?

Accessing HBC Adult Services information and advice	Yes/ No
A needs assessment	Yes/ No
A carers assessment	Yes/ No
Care planning	Yes/ No
Review of a careplan	Yes/ No
A child's needs assessment	Yes/ No
Safeguarding enquiry / review	Yes/ No

Please note that if your referral involves a possible change of accommodation it may be that the decision maker (usually a social worker or health caseworker) has a legal duty to offer Independent Mental Capacity Advocacy (IMCA) as well as Care Act Advocacy in which case the hub will request additional referral information / referral from you.

Please give more information about the issues that the person needs advocacy support for:

(please indicate)

Has the patient/ individual received Advocacy support before? **YES/NO/DON'T KNOW**

If yes, name of Advocate/ Provider:

ARE THERE ANY DEADLINES OR IMPORTANT MEETING DATES?

CONTACT DETAILS:			
Care Coordinator:			
Address:			
Postcode:		**Telephone:**	
Email:		**Fax:**	
GP:			
Address:			
Postcode:		**Telephone:**	
Email:		**Fax:**	
Nearest Relative:			
Address:			
Postcode:		**Telephone:**	
Email:		**Fax:**	

DECLARATION:

Because of the General Data Protection Regulations 2018 a signature is needed to say that you agree to the Advocacy Hub securely holding personal information (including the information on this form), on a computer and in a filing system. It is the policy of the Advocacy Hub that all personal data will be held in accordance with the principles and requirements of the General Data Protection Regulations 2018 and other relevant legislation, and that procedures will be put in place to ensure the fair processing of data relating to individuals. The Advocacy Hub is a confidential service; you can request further information on confidentiality from ourselves, or the appropriate advocacy service.

I agree to that the Advocacy service can securely hold, and put on computer and in a filing system, the information on this form.

MUST BE SIGNED AND DATED

SIGNATURE	
DATE	

THE REFERRER (leave blank if signed by Service User) I would like the Advocacy Hub to do this work. They can keep, and put on computer and in a filing system, the information on this form provided to do the work. I am providing this information and asking for this referral in the Service User's best interests.

MUST BE SIGNED AND DATED

SIGNATURE	
PRINT NAME	
DATE	