Your life. Your choice. Your voice.
sam
Swindon Advocacy Movement

Swindon Advocacy Movement
Sanford House
Sanford Street
Swindon
SN1 1HE

Swindon Advocacy Movement

Care Act Advocacy Service Referral Form

Criteria:
The client must be a resident in Swindon at the time of referral. We can only accept a referral if the person needing an advocate has given their consent. If the referrer believes they do not have the capacity to consent they must give brief details on the 'additional information' section of the referral form.
The client must:

- **Have been assessed as having substantial difficulty in being involved in the process and**
- **Not have anyone other than paid staff willing or appropriate to support them**

Please complete all sections of the referral. Failure to do so may result in a delay

Client Details	
Name:	**Date of Birth:**
Home Address **Postcode:** **Tel No:**	**Current location of client: (in not at home address)** **Postcode:** **Tel No:**
Nature of client's condition (please tick one or more as appropriate) ☐ Learning Disability ☐ Mental Illness ☐ Dementia ☐ Aging (Over 60) ☐ Serious Physical Illness ☐ Acquired Brain Injury ☐ Autistic Spectrum Disorder ☐ Other, Please specify	**Preferred Communication method (please indicate and give brief details as appropriate)** ☐ English ☐ Other spoken language ☐ Pictures/symbols/Makaton ☐ British Sign Language ☐ No Obvious communication ☐ Gestures/vocalisations/facial expressions ☐ Other, please specify

Has the client been formally assessed as having a substantial difficulty as defined in the Care Act 2014? Yes/No
Name and job title of assessor:

Date of the assessment and issue for which they were assessed:
Has the client consented to the referral? (If no provide details in additional information) **Yes/No**
<u>**Support required for:**</u> **(please indicate as appropriate)** An independent advocate **must** be appointed to support and represent the person for the purpose of assisting their involvement if <u>these two conditions</u> are met and if the person is required to take part in one or more of the following processes; ☐ Care Act Assessment ☐ Care and Support Planning ☐ Carers Assessment ☐ Preparation/Review of a Care and Support Plan or Support Plan ☐ Safeguarding Section 42 Enquiry/Review* ☐ Appeal against a local authority decision under Part 1 of the Care Act *We are unable to provide advocacy unless a Section 42 enquiry has been opened
Does the client have family or close friends appropriate to support them? **Yes/No** **If there are family and or friends why is an advocate needed?** Care Act Guidance state advocacy is needed where there is no other appropriate adult to help them.
Safeguarding Referrals: Is the person aware a concern has been reported about their safety? **Yes/No**
Or is there a disagreement between the LA and appropriate person they both agree an advocate would be beneficial. **Yes/No**
Or is an appeal against the LA decision being made? **Yes/No**
Is a placement being considered in NHS funded provision in a hospital (4 weeks +) or a Care Home (8 weeks +) **Yes/No**

<u>**Referrer Details**</u>	
Referral Name:	**Position:**
Telephone/Mobile No:	**Email:**
Team/Department:	**Agency or Provider**
What is the best way to contract the client (if appropriate)	
Risk Assessment: Please complete:	
This section needs to be completed for us to provide a service to the client. Failure to complete may result in delaying the appointment of an advocate. Please indicate below anything in the clients	

history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home
Any know mental health issues:
Any behaviours we need to know about:
Any know risks in lone working/visiting at home ie friends, family, history etc:
Any particular health needs ie Epilepsy, Asthma etc:
Please give details of any important deadlines or meeting dates:

In accordance with Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client

Would you like to go on our mails for AGM etc Yes/No

Signed Client:	Date:
Signed Referrer:	**Date:**

"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment"

Please send the above referral to: Swindon Advocacy Movement, Sanford House, Sanford Street, Swindon, SN1 1HE. Telephone Number 01793 542575/542266

Email: secure@swindonadvocacy.co.uk

****Referral Receipt** SAM will confirm receipt of all referrals within 24 hours Monday – Friday. Please contact SAM if you have not received confirmation of receipt.**

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Telephone on 01793 542575

EQUALITY AND DIVERSITY MONITORING FORM

Swindon Advocacy Movement is committed to encouraging equality, diversity and inclusion among our workforce, volunteers and clients eliminating unlawful discrimination.

In order to ensure the continued development of our Equality, Diversity and Inclusion Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
Are you Married or in a Civil Partnership			Yes		No	Prefer not to say	
Gender:	Male	Female		Transgender		Prefer not to say	
Sexual Orientation:	Heterosexual	Gay man	Gay woman/ Lesbian		Bisexual	Prefer not to say	
Religion:	Christian	Muslim	None		Buddist	Jewish	
	Sikh	Hindu	Other (please state)			Prefer not to say	
Employment Status:	Employed	Unemployed	Registered Disabled	Retired	Student	Prefer not to say	
Age Groups	Under 16	16- 24	25-34	35-44	45-54	55-64	65+	Prefer not to say
Post Code:			**Prefer not to say**				

Ethnicity:			
White British		Asian – British or Indian	
White Irish		Asian – British or Pakistani	
White Other		Asian – British or Bangladeshi	
Please specify;		Any other Asian background	
Mixed – White & Black Caribbean		Black – British or Black Caribbean	
Mixed – White & Black African		Black – British or Black African	
Mixed –White & Asian		Other Black	
Mixed – White Other		Oriental - Chinese	
Any other mixed background		Oriental – Other	
Prefer not to say		Not Established	

Disability:					
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? **Please tick**					
Yes		No		Prefer not to say	

If you have answered yes to the question above, how would you best describe your disability. **Please tick all that apply**							
Hearing		Speech		Physical		Mental Health	
Visual		Mobility		Learning		Other	