# **ASK 4 Advocacy – Referral Form**

This referral form is for all types of advocacy. You can complete this form on your own behalf (self-referral) or on behalf of someone else. Part 1 **must** be completed and depending on the advocacy required please complete other relevant parts.

**Incomplete forms may be returned which can result in delay in allocating an advocate.**

Referral forms can be emailed via secure email to: advocacy@touchstonesupport.org.uk. If you do not have a secure email system you can password protect the form and send the password in a separate follow-up email.

**Advocacy Required** (please only select **ONE option** by putting an **X** in the box)

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| **General Advocacy**  (part 1 & 5 of form) | **Community Mental Health**  (part 1 & 5 of form) | **Parents Advocacy**  (part 1 & 5 of form) | **IMCA**  (part 1, 2 & 5 of form) | **Care Act**  (part 1, 3 & 5 of form) | **IMHA**  (part 1, 4 & 5 of form) | **NHS Complaints**  (part 1 & 5 of form) |
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| How did you hear about this service? |  | Date of referral |  |

**Part 1: Referral Information**

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| **Client Details:** (person requiring advocacy) | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | |
| Home Address: | | | | | Current Address / ward / unit (if different): | | | | | | | |
| Postcode: | | | | | Postcode: | | | | | | | |
| Home tel number: | | | | | Current tel number: | | | | | | | |
| Can we leave a message? | | | Yes |  | No | |  | | | | | |
| Date of Birth (DD/MM/YY): | | |  | | Gender | |  | | | | | |
| Has consent been given to you to make this referral by the person requiring advocacy? If **No** please provide details why: | | | | | | | | | Yes |  | No |  |
|  | | | | | | | | | | | | |
| **Reason for advocacy referral**? (Please include a summary of the advocacy issue/decision being made, upcoming meeting dates, deadlines, priority areas etc.) | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Referrer Details:** | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | |
| Role / Job Title: | |  | | | | | | | | | | |
| Organisation: | |  | | | | | | | | | | |
| Place of work:  (ward / unit / team - including address) | |  | | | | | | | | | | |
| Phone Number: | |  | | | | Mobile: | |  | | | | |
| Email Address: | |  | | | | Secure email: | |  | | | | |

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| **Friends and/or family:** | | | | |
| Is there anyone (e.g. friend/relative) who can actively support the person’s involvement in the decision(s) being made or who we need to consult with? | Yes |  | No |  |
| If you have answered **Yes** above, please provide contact details for the person(s) including their relationship to the person requiring advocacy. | | | | |
|  | | | | |
| Has anyone been ruled out of being consulted with, or supporting the person requiring advocacy? If **Yes**, please say below and the reason why. | Yes |  | No |  |
| Have you informed the person named below that they are not able to support the person requiring advocacy? If **No** please say why. | Yes |  | No |  |
|  | | | | |
| Are there any current **Risk Issues** we need to be aware of? If **Yes** please provide details below and risk assessment if available. | Yes |  | No |  |
|  | | | | |

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| **Other relevant information about the person requiring advocacy.** *Please select all that apply.* | | | | | | |
| Acquired Brain Injury |  | | Dementia | | |  |
| Autistic Spectrum Disorder |  | | Learning Disability | | |  |
| Blind / partially sighted |  | | Long term health condition | | |  |
| Carer |  | | Mental Health Needs | | |  |
| Cognitive Impairment |  | | Older Person | | |  |
| Deaf |  | | Physical condition/illness | | |  |
| Other (please state): |  | | | | | |
| **Please state how the person requiring advocacy communicates.** *Please select all that apply.* | | | | | | |
| British Sign Language (BSL) |  | Gestures |  | Verbally |  | |
| Cue Cards |  | Makaton |  | Writing |  | |
| First Language (please state) |  |  | | Other (please state) |  | |
| Any other relevant information? | | | | | | |

**Part 2: Independent Mental Capacity Advocacy (IMCA)**

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| **What is the reason for this referral?** | | | |
| Care Review |  | Safeguarding |  |
| Change of Accommodation |  | Serious Medical Treatment |  |

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| Is the person currently an inpatient? | | | Yes |  | No |  | Hospital |  | |  | | |
| Ward |  | | | | Ward direct tel: | | |  | |  | | |
| Have you assessed the person as lacking capacity in relation to the referral issue?  (Due to an impairment or disturbance in the functioning of the brain which means the person cannot understand, retain or weigh up information, or communicate their wishes or feelings) | | | | | | | | | Yes |  | No |  |
| If **Yes**, when was this assessment carried out (DD/MM/YY)  (We may ask for a copy of this assessment, please have it available on request) | | | | | | | | |  |  | | |
| Does the person requiring advocacy have an appropriate person to support them as identified in part 1? | | | | | | | | | Yes |  | No |  |
| **Decision Maker Details (if the referrer is the decision maker please tick this box)** | | | | | | | | | |  |  | |
| Name: | |  | | | | | | | | | | |
| Role / Job Title: | |  | | | | | | | | | | |
| Place of work:  (including address) | |  | | | | | | | | | | |
| Phone Number: | |  | | | | | | | | | | |
| Email Address: | |  | | | | | | | | | | |

**Part 3: Care Act Advocacy Referrals (CAA)**

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| **Does the person:** | | | | | **Yes / No** | | | **Please provide details** | |
| Does the person requiring advocacy have **substantial difficulty** in engaging with, or understanding the referral issue?  (e.g. difficulty understanding, retaining, using / weighing up information or communicating their wishes and feelings) | | | | |  | | |  | |
| Does the person requiring advocacy have an appropriate person to support them as identified in part 1? | | | | |  | | |  | |
| **Is the person going through a social care process?** *Please tick below:* | | | | | | | | | |
| Safeguarding |  | Care Review |  | Assessment of Need | |  | Preparation of care / support plan | |  |

**Part 4: Independent Mental Health Advocacy (IMHA)**

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| **Is the person:** | | **Yes / No** | **Details** |
| Detained under a section of the Mental Health Act 1983? *(Please state which section and* ***start date of section****)* | |  |  |
| A conditionally discharged restricted patient? | |  |  |
| Subject to a community treatment order? (CTO) | |  |  |
| Subject to a guardianship order? | |  |  |
| Under 18 and being considered for ECT (electroconvulsive therapy) or a section 58a treatment? | |  |  |
|  | | | |
| **Additional Contacts:** | | | |
| Name of Responsible Clinician (RC) |  | | |
| Name of Nearest Relative |  | | |
| Relationship of Nearest Relative to the person |  | | |

**Part 5: Monitoring**

The following information is collected to help us create equal opportunities for individual’s resident within our local communities. We use this information anonymously to identify if the diversity of the people accessing our services fully reflects the communities we serve. When it doesn’t this information helps us to make new links with services and organisations, support equality and diversity and promote equal access to our services.

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| --- | --- | --- | --- | --- |
|  | | **Ethnicity** | | |
| White (British) | |  | Asian/Asian British (Indian) |  |
| White (Irish) | |  | Asian/Asian British (Pakistani) |  |
| White (Other) | |  | Asian/Asian British (Other) |  |
| Black/Black British (African) | |  | Mixed: White/Black African |  |
| Black/Black British (Caribbean) | |  | Mixed: White/Black Caribbean |  |
| Black/Black British (Other) | |  | Mixed: White/Asian |  |
| Asian/Asian British (Chinese) | |  | Mixed: Other |  |
| Asian/Asian British (Bangladeshi) | |  | Prefer not to say |  |
| Other (please state) |  | | | |

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| **Religion** | | | | |
| Buddhist |  | Muslim | |  |
| Christian |  | Sikh | |  |
| Hindu |  | No Belief | |  |
| Jewish |  | No Religion | |  |
| Other (please state) |  | | Prefer not to say |  |

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| **Gender** | | | | | | |
| Female |  | Non-binary |  |  | Trans female |  |
| Male |  | Trans male |  |  | Prefer not to say |  |

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| **Sexuality** | | | | | |
| Heterosexual |  | Lesbian |  | Gay |  |
| Bisexual |  | Pansexual |  | Prefer not to say |  |
| Other: (please specify) |  | | | | |

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| **Ex-Service Personnel** | | | | | | |
| No |  | Yes (Spouse) |  |  | Prefer not to say |  |
| Yes (Self) |  | Yes (Dependent) |  |  |  |  |

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| **Touchstone Service User Privacy Statement**  Touchstone is committed to protecting and respecting your privacy and keeping your data secure. By providing us with your data you are giving us your consent to process your data. We will only process your personal data to provide you with the service that you have requested from us and provide (anonymous) feedback to our commissioners and funders. To read our Service User Privacy Notice, please visit:  <https://www.touchstonesupport.org.uk/home/contact-us/service-user-privacy-notice/>  Or for our Privacy and Cookies Policy, please visit:  <https://www.touchstonesupport.org.uk/home/contact-us/privacy-policy/>  Or contact us: Touchstone House, 2-4 Middleton Crescent, Leeds, LS11 6JU, telephone: 0113 271 8277 or via email: [office@touchstonesupport.org.uk](mailto:office@touchstonesupport.org.uk) |

## **Referral Form Guidelines**

Please read these guidelines to assist you in completing the Advocacy referral form for all types of advocacy provided through Ask 4 Advocacy.

Incomplete forms will require following up with the person who has completed it and this may create a delay in allocating an advocate and commencing advocacy work.

**Such forms may be returned for completion.**

**Advocacy type**: There are different types of advocacy which sit under different legislation and include statutory and non-statutory. Please select the type of advocacy required which includes General, Community Mental Health, Parents Advocacy, Health Complaints, Care Act (CCA), Independent Mental Capacity (IMCA) and Independent Mental Health Advocacy (IMHA). For further information on the types of advocacy you can refer to Ask 4 Advocacy Standard Operating Procedures (SOPS).

**Please select only one form of advocacy per referral**.

* *Please contact to discuss if unsure which advocacy type is most appropriate*

**Part 1:** All referrers or individuals requiring advocacy must complete **all** the fields in part 1. This is the minimum information required to accurately determine how we can best support the person requiring advocacy and to ensure Advocacy is the right service for them.

1. Client details refer to the person requiring advocacy (relevant person/client). Inaccurate contact details will result in a delay in commencing work and/or gaining instruction from the client.
2. **Consent** is required where a person has capacity to instruct an advocate on their behalf. Advocates cannot be retained where a client with capacity has not given consent for the referral. Should a client say they do not want an advocate an advocate will not be allocated. Where an individual lacks capacity to instruct, consent to act is provided by the referrer/decision maker.
3. Reason for the advocacy referral needs to clearly state what the advocacy issue or barrier that is preventing the client from being involved and having a say in decisions being made is. It is not sufficient to say the person requires ‘support’. It’s important to include any needs, meeting dates or priority issues which will help when processing and allocating referrals.
4. Referrer details are required so we can follow up if further information is required.
5. Individuals can often be supported by family or friends to advocate on their behalf. Where an appropriate person has been requested or identified please include their details. If a person is not considered appropriate please state why. Having a difference of opinion does not automatically mean a person is not appropriate to consult with and/or advocate for the client.
6. Information about risks is required as advocates’ often lone work and we need to ensure the safety of both staff and clients by managing any risks disclosed. Ask 4 Advocacy manages risk and works on the basis of current risk rather than historical risk unless this remains relevant.
7. Other relevant information enables us to offer an appropriate level of support based on the client’s needs including communication methods.

Any supporting documents such as capacity assessments, care plans etc. should wherever possible, accompany the referral form. Any delays in receiving or accessing relevant documents will result in delays in advocacy work starting and progressing.

**Part 2:** This section needs to be completed **in addition** to part 1, if you are referring someone who is eligible under the Mental Capacity Act 2005 (MCA) who requires an Independent Mental Capacity Advocate (IMCA). *Please complete all the relevant fields*.

**Part 3:** This section needs to be completed **in addition** to section 1, if you are referring someone who is eligible under the Care Act 2014 (CA) who requires a Care Act Advocate (CAA). *Please complete all the relevant fields*.

**Part 4:** This section needs to be completed **in addition** to section 1, if you are referring someone who is a qualifying patient detained under the Mental Health Act 1983 (MHA) who requires an Independent Mental Health Advocate (IMHA). *Please complete all the relevant fields*.

**Part 5: Monitoring**

*Non-binary* refers to individuals who don’t see themselves as either male or female. Individuals identifying as non-binary may ask you to use gender neutral pronouns such as they/their rather than he/she. Please do not ask non-binary individuals the sex or gender assigned to them at birth as this is irrelevant.

*Trans* male/female refers to individuals who are transitioning to the gender they identify with.

*Pansexual* refers to individuals who are romantically, emotionally, sexually attracted to people regardless of their sex and gender identity.

**Returning the referral form:** Referral forms can be emailed via secure email to: advocacy@touchstonesupport.org.uk. If you do not have a secure email system you can password protect the form and send the password in a separate follow-up email.

**Referral Process:** Once received, the referral form will be checked and entered onto our secure database system. Any incomplete forms will need to be follow-up and this may delay allocating an advocate.

Once the information has been checked the case will be placed on the waiting list and allocated to a named advocate. Please be aware that allocating means that the named advocate will then plan in a time to meet the client to gain consent and instruction, where they have capacity, and contact other relevant professionals.

Referrals received where dates for Best Interests or other meetings have been set to occur in a short timescale may result in a request to reschedule the planned meeting to enable the advocate to be present. Where meeting dates have still to be arranged please ensure you consult with the named advocate when arranging these dates to ensure they are available along with other professionals.

**Advocacy work:** Advocacy supports a person’s statutory and human rights and their involvement in decision making processes. For advocacy to be meaningful time is required to ascertain the person’s wishes, views and opinions and where capacity is lacking those of family, friends and other professionals. This information is then used to ensure the person has a say. Referrals that do not allow sufficient time for this to take place don’t support the advocacy principles under which we work.