

# Devon and Torbay Advocacy Service

## CARE ACT REFERRAL FORM

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| ***For Information and advice on how to complete this form please phone the Devon Advocacy Consortium on 01392 822377 or read the Referral Guidance notes on the DAC website:*** [***http://www.devonadvocacy.org.uk/documents***](http://www.devonadvocacy.org.uk/documents)***Failure to complete all relevant parts of this form will result in delayed allocation of this referral.******The referral form should be emailed to*** ***devonadvocacy@livingoptions.org*** |

### DETAILS OF THE PERSON BEING REFERRED

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | D.O.B |  |
| Permanent Address |  | Age |  |
| Gender |  |
| Postcode |  | Tel |  |
| Current address |  | Tel |  |
| Postcode |  | Email |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client currently living in | Own home |  | Care home |  | Hospital |  | Supported living |  | Prison |  | Uncertain |  | Other (specify) |  |

**REFERRAL REASON**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the person subject to an open Safeguarding Enquiry? | Yes |  | No |  |
| Is the person subject to a Safeguarding Adults Review?  | Yes |  | No |  |
| Is the person having an assessment of their care and support needs? | Yes |  | No |  |
| Is the person having a carer’s assessment? | Yes |  | No |  |
| Will there be a preparation of a care or support plan? | Yes |  | No |  |
| Is there a review of a care or support plan?  | Yes |  | No |  |
| ***Please note: If you have ticked no for all areas, the person is not eligible for Care Act Advocacy.***  |

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| --- | --- |
| Details of the reason for referral |  |
| Dates & times of any planned meetings |  |
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| --- |
| Please use this space to provide any other relevant information: |
|  |

**SUBSTANTIAL DIFFICULTY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the person able to understand relevant information? | Yes |  | No |  |
| Is the person able to retain information? | Yes |  | No |  |
| Is the person able to use or weigh information?  | Yes |  | No |  |
| Is the person able to communicate their views, wishes and feelings?  | Yes |  | No |  |
| ***Please note: If yes to all of the above then the person is not eligible for Care Act Advocacy.***  |

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| Disability  |
| Acquired Brain Injury |  | Autistic Spectrum Condition |  | Cognitive impairment |  | Dementia  |  |
| Learning Disability |  | Mental Health problems |  | Serious Physical Illness |  | Combination |  |
| Unconsciousness |  | Other (please state) |  |

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| **APPROPRIATE INDIVIDUAL** |
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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the person have anyone available to facilitate their involvement? | Yes |  | No |  |
| ***If yes, the person is not eligible for Care Act Advocacy. If no, please give reason below:*** |
| Only paid or professional help available | Yes |  | No |  |
| No friend / family member available | Yes |  | No |  |
| No friend / family member without a conflict of interest | Yes |  | No |  |
| No friend / family member acceptable to the person | Yes |  | No |  |
| Other reason, please give details: |  |  |  |  |
| Does the person / family agree to the referral being made? | N/A |  | Yes |  | No |  |

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| Does the person being referred pose a risk to themselves or others? Yes |  | No |  |
| Details: |  |

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| What is the primary communication method? (tick only one box – the most appropriate) |
| English |  | Other spoken language |  | Gestures/vocalizations/facial expressions |  |
| Sign language (e.g. BSL) |  | Words/Pictures/Makaton |  | No obvious means of communication |  |
| Other (please state) |  |

**REFERRER**

|  |
| --- |
| ***Please note: We can only accept referrals from statutory services.***  |
| Name |  | Name of Org |  |
| Profession |  | Work Tel |  |
| Address |  | Mobile |  |
| Email |  |

**additional contacts**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name |  |
| Relationship |  | Relationship |  |
| Address |  | Address |  |
|  |  |
| Tel |  | Tel |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Name |  |
| Relationship |  | Relationship |  |
| Address |  | Address |  |
|  |  |
| Tel |  | Tel |  |

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| --- | --- | --- | --- | --- | --- |
| **CLIENT MONITORING INFORMATION****We are required to request the following data to ensure that our service is fair and treats our users equally. This information is separate to your referral for advocacy and has no impact on the service that we will provide.****The following questions are optional.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the gender the client identifies with the same as their sex registered at birth? | Yes |  | No |  |

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| **White:** |  | **Mixed:** |  | **Asian or Asian British:** |  | **Black or Black British:** |  | **Other** |  |
| British |  | White & Black Caribbean  |  | Indian |  | Black Caribbean |  | Other Ethnic Group (please specify) |  |
| Irish |  | White & Black African |  | Pakistani |  | Black African |  | Not Established |  |
| Other White (please specify) |  | White & Asian |  | Bangladeshi  |  | Other Black (please specify) |  |  |  |
|  |  | Other Mixed(please specify) |  | Chinese |  |  |  |  |  |
|  |  |  |  | Other Asian (please specify) |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| Is the client married or in a civil partnership? | Yes |  | No |  |

|  |  |
| --- | --- |
| How does the client describe their sexual orientation? |  |

|  |  |
| --- | --- |
| What religion is the client? |  |

The Devon Advocacy Consortium is a partnership made up of 4 specialist advocacy providers: Living Options Devon (lead), Rethink Advocacy, Vocal Advocacy and Young Devon.

Devon Advocacy Consortium

Living Options Devon

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