Swindon Advocacy Movement
Sanford House
Sanford Street
Swindon
SN1 1HE

Care Act Advocacy Service Referral Form

There are many types of advocacy services and they all have differing criteria. If you need any help regarding which type of advocacy is needed, please visit https://www.swindonadvocacy.org.uk/ or contact us on 01793 542575 for more information.

Not everyone is entitled to advocacy under the Care Act. Make an advocacy referral when all three conditions apply:

1. one of these processes is taking place: social care needs assessment, carers assessment, care planning, care review or S42 safeguarding investigation
2. without support, the person will have **substantial difficulty** being involved
3. there are no appropriate, able and willing family or friends to support the person's active involvement

There are **3 situations** where an **advocate must be involved** even if there is an appropriate individual to support them. These are:

if a person is being funded by the NHS in a hospital for more than 4 weeks
If a person is being funded by the NHS in a care home for more than 8 weeks
AND the LA believes that arranging an advocate would be in the person's best interest or;

If there is a **disagreement** between the **local authority** and the **appropriate individual** and **all agree** that the involvement of an **advocate would benefit the person**

Client Details	
Name:	**Date of Birth:**
Home Address **Postcode:** **Tel No:**	**Current location of client** **Postcode:** **Tel No:**
Referrer Details	
Referrer Name:	**Position:**
Telephone:	**Email:**
Team/Department:	**Agency or Provider:**

Advocacy

Advocacy support required for which process under the Care Act:

- ☐ 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*
- ☐ Appeals 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

If this is a Safeguarding Referral, please indicate whether the issue involves:

- ☐ Hate Crime
- ☐ Hoarding
- ☐ Self-Neglect
- ☐ Criminal Exploitation
- ☐ Domestic Abuse
- ☐ Financial Abuse
- ☐ Neglect

Is the individual aware that a safeguarding concern has been reported about their safety? **Y / N**

Details:
Please give details of what has triggered the process above eg what is the Safeguarding Concern, or what is the family situation that has triggered a Carers Assessment, why the client has not been made aware of the safeguard alert, etc?

Your life. Your choice. Your voice.

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Swindon Advocacy Movement

Advocacy QPM AWARD

Person Centred

To support us in our efforts to always provide a person-centred advocacy service please share as much detail as possible around how the client likes to work / be supported. This could include how they communicate (BSL, Makaton, gestures, etc), whether they have any support (professional or family and friends), are they isolated:

Condition / Disability

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

Details:

Risk Assessment
Please be aware, advocates are lone workers who often visit clients at home. **Please indicate below anything in the client's history or health needs which may give rise to potential risks or dangers either to themselves or to others eg mental ill health, asthma, epilepsy, domestic violence perpetrator in the home, etc**

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

If the client has not consented to this referral, please provide details

"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"

Independent advocacy is about giving the person as much **control** as possible over their life. It helps them **understand information, say what they want** and **what they need.**

Send referral to our secure email secure@swindonadvocacy.co.uk

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.

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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**	