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| **asist main logo 2010Spot Purchasing Advocacy Referral Form ©** |  |

Service available Monday to Friday 9am to 5pm (excluding bank holidays)

**Eligibility Checklist**

Not Eligible

The person is 18+ **and**

Has a Disability (learning/ sensory/ physical), or mental health need.

YES

NO

Services Available

Please complete the attached referral form.

For further information please contact the Asist office.

In times of high demand, not all referrals may be accepted, and it may not be possible for an advocate to attend all dates on the referral form.

**NHS Continuing Healthcare / Health related Issues**Complaints

**Parental Advocacy**

Child In need/ Child Protection/ PLO and Care proceedings

**Care Act and Social Care**

Care and support Planning/ Assessments/ reviews

**DoLS/ RPR/ Community DoLS**

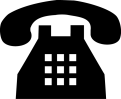
**BAME Advocacy**

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| **To discuss a referral please contact Asist on 01782 845584** |

**Fill in this form and send to Asist by emailing** [**referrals@asist.co.uk**](mailto:referrals@asist.co.uk)

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| **asist main logo 2010Spot Purchasing Advocacy Referral Form** | | | | | | | | | | | | | | | | | | | | |  | |
| **Service available Monday to** Friday 9am to 5pm (excluding bank holidays) | | | | | | | | | | | | | | | | | | | | |  | |
| **The person requiring support** | | | | | | | | | | | | | | | | | | | | | |
| **Mrs/ Mr:** | | **Name:** | | | | | | | | | | | | | **Date of birth:** | | | | | | |
| **Gender:** | | **Preferred Pronouns:** | | | | | | | | | | | | | **Mobile:** | | | | | | |
| **Current Address:** | | | | | | | | | | | | | | | **Tel:** | | | | | | |
| **Postcode:** | | | | | | |
| Sexual orientation): | | | | | | | | | | | | | | | | **Email:** | | | | | |
| Religion; please include any cultural or religious needs) | | | | | | | | | | | | | | | |
| **How does this person Communicate?** | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Language:** | | | | | | | | | **Dialect:** | | | | | | | | | | | | |
| **Spoken Language** | | | | | | | |  | **Words/ Pictures/ Makaton** | | | | | | | | |  | | | |
| **British Sign Language** | | | | | | | |  | **Gestures/ Facial expressions/ Vocalisations** | | | | | | | | |  | | | |
| **Other, please give details:** | | | | | | | | | | | | | | | | | | | | | |
| **Known risks (to themselves or others):** Please include if the person is currently Covid positive any historical risks, environmental factors, etc | | | | | | | | | | | | | | | | | | | | | |
| **What is the person’s additional support needs?** | | | | | | | | | | | | | | | | | | | | | |
| **Mental Health Problems** | | | | | | | |  | **Physical Health** | | | | | | | | |  | | | |
| **Cognitive Impairment** | | | | | | | |  | **Autism Spectrum Condition** | | | | | | | | |  | | | |
| **Learning Disability** | | | | | | | |  | **Serious Physical Illness** | | | | | | | | |  | | | |
| **Other:** | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity** | | | | | | | | | | | | | | | | | | | | | |
| **White** | **Asian or Asian British** | | | | | **Mixed** | | | | | **Black or Black Irish** | | | | | | **Chinese or not established** | | | | |
| British  Irish  other | Pakistani  Bangladeshi  Indian | | | | | White & Black Caribbean  White & Black African  White & Asian | | | | | Black Caribbean  Black African | | | | | | Chinese  Ethnicity not established | | | | |
| **Other, please specify** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Who is the referral for?** | | | | | | | | | | | | | | | | | | | | | |
| **An adult with care and support needs** | | |  | | | | **A carer with support needs** | | |  | | | **A parent of a child open to Children’s Social Care** | | | | | |  | | |
| **Type of Advocacy process (Please only pick one process per referral form)** | | | | | | | | | | | | | | | | | | | | | |
| **DoLS/RPR** | | | |  | **Care Act** | | | | | | |  | | **Parental** | | | | | |  | |
| **CHC Assessment** | | | |  | **Health Issues** | | | | | | |  | | **BAME** | | | | | |  | |
| **What process does the person require support with? (Please tick one per referral form)** | | | | | | | | | | | | | | | | | | | | | |
| **Assessment** | | | |  | **Care & Support Planning** | | | | | | |  | | **Review** | | | | | |  | |

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| **Safeguarding Enquiry** |  | **Safeguarding Adult Review** | | | | | |  | **Complaints** | | | | |  |
| **Child In Need** |  | **Child Protection** | | | | | |  | **PLO/ Care Proceedings** | | | | |  |
| **Health issues** |  | **DoLS/RPR** | | | | | |  | **Cultural issues** | | | | |  |
| **Legal issues** |  | **Activities** | | | | | |  | **Other:** | | | | | |
| **Nature of Substantial Difficulty (please tick all that apply)** | | | | | | | | | | | | | | |
| **Understanding relevant information** | | | |  | | **Retaining information** | | | | |  | | | |
| **Using or weighing up information** | | | |  | | **Communicating their views, wishes and feelings** | | | | |  | | | |
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| **asist main logo 2010Please confirm that there is no one appropriate OR available to facilitate the persons active involvement.** | | | | | | | | | | | | | | |
| **I confirm that there is no one appropriate or available to facilitate involvement:** | | | | | | | | | | | |  | | |
| **How does this person communicate?** | | | | | | | | | | | | | | |
| **Preferred Language:** | | | | | **Dialect:** | | | | | | | | | |
| **Spoken Language** | | |  | | **Gestures/Facial Expressions/Vocalisations** | | | | | | | |  | |
| **British Sign Language** | | |  | | **Words/Pictures/Makaton** | | | | | | | |  | |
| **Other, please specify:** | | | | | | | | | | | | | | |
| **Additional Information** | | | | | | | | | | | | | | |
| **Brief summary of situation and reason for requesting an Advocate.**  Please provide any additional background information which will help the Advocate to support the person being referred.  What steps need to be taken to maximise the person’s full participation (For example, consideration of mental capacity, sensory needs, autism related needs and confidence.  This could also include interpreters, appropriate adult, family members, information and advice, communication aid, appropriate time of day/effects of medication, suitable environment). | | | | | | | | | | | | | | |
| **Please give details of any meeting dates/process.** Please include any dates/ times/ locations (virtual, in person, office based or at the persons home address), meeting duration, issue or meeting, etc | | | | | | | | | | | | | | |
| **Please provide any further information you believe is relevant to the referral.**  Are there other professionals involved with this referral? | | | | | | | | | | | | | | |
| **Referrer Contact Details** | | | | | | | | | | | | | | | |
| **Name of referrer:** | | | | | | | **Job Title:** | | | | | | | | |
| **Team:** | | | | | | | **Organisation:** | | | | | | | | |
| **Email:** | | | | | | | **Tel:** | | | | | | | | |
| **Date of Referral:** | | | | | | | **How did you hear about us** | | | | | | | | |
| **To be completed by Children and Young Peoples Services only** | | | | | | | | | | | | | | | |
| **Adult Social Care (ASC) Assessor Details** | | | | | | | | | | | | | | | |
| **Are or will ASC be involved?** | | | | | | | | | | | | | | | |
| **Name of ASC Social Worker/ Assessor:** | | | | | | | | | | | | | | | |
| **Team (if known):** | | | | | | | | | | | | | | | |
| **Telephone Number:** | | | | | | | **Email address:** | | | | | | | | |
| **Managers Authorisation** | | | | | | | | | | | | | | | |
| **Team Managers Name:** | | | | | | | **Organisation**: | | | | | | | | |
| **Email address:** | | | | | | | **Telephone Number:** | | | | | | | | |
| **Team Managers Signature** *(electronic):* | | | | | | | **Date:** | | | | | | | | |
| **Consent** | | | | | | | | | | | | | | | |
| **Have you discussed this referral with the person being referred? (Where appropriate)** | | | | | | | | | |  | | | | | |
| **Has the person agreed to this referral being made?** | | | | | | | | | |  | | | | | |
| **Disclaimer** | | | | | | | | | | | | | | | |
| *Please note that in some cases, multiple advocates may support the advocacy partner (you will be informed of this). Once the case is allocated, an advocate will be in contact to discuss the case and their availability.* | | | | | | | | | | | | | | | |
| **Please note that we may not be able to attend all meetings listed on the referral form. Where possible, provide us with 2 weeks-notice for any meetings to allow the advocate adequate time to support the advocacy partner.** | | | | | | | | | | | | | | | |
| Upon receipt of a referral, we will process it and issue you with our case reference number. The referral will then be reviewed to check eligibility and availability of our advocates. ASIST will make contact to confirm invoicing information and completion of our authorisation form. This ***must***be completed before the case can be allocated to an advocate and before any work can proceed. | | | | | | | | | | | | | | | |
| **The referrer is responsible for providing ASIST with accurate, up to date information and contact details, and updating ASIST with any new information or, amendments to information provided on the referral form after it has been submitted. PLEASE make sure information is correct before submitting this form.** | | | | | | | | | | | | | | | |

**Fill in this form and send to Asist by emailing** [**referrals@asist.co.uk**](mailto:referrals@asist.co.uk)

**Head Office: Asist, Winton House, Stoke Road, Stoke-on-Trent, ST4 2RW**

