OAD

citizens advice

ONE Advocacy Derby

Specialist Advocacy and Care Act Referral Form

Date Received:

Specialist Advocacy:		Care Act:	

Client ID:	

Client Details

Client Name:		Date of Birth:	
Current Address:			
Home Address: (if different)			
Contact Number(s):			

Male:		Female:		Prefer Not to Say:	

White British		Black Caribbean		Mixed Caribbean		Indian		Mixed White	
Irish		Black African		Mixed African		Pakistani		Other Asian	
White Other		Black Other		White/Asian		Bangladeshi		Chinese	

How does the person communicate?

Spoken English		Another Spoken Language		Gestures/Facial Expression/Vocalisations	
BSL		No Obvious Communication		Pictures/Symbols/Makaton	
Other: (give details)					

Nature of client's impairment (mark all that apply)

Unconsciousness		Mental Health Problems		Acquired Brain Damage		Learning Disability	
Autism Spectrum		Serious Physical Illness		Dementia		Cognitive Impairment	
Other: (give details)							

Is this advocacy under the Care Act? If **Yes** please complete the following boxes, if **No** please go to **Next Page**	**Yes**		**No**	
Has the **client** been **assessed by referrer** as having **substantial difficulty** to engage in assessment/safeguarding process?	**Yes**		**No**	
Has the client been **deemed by referrer** as having **no appropriate person** to support them to engage in assessment/safeguarding process?	**Yes**		**No**	
If there are persons involved with the client but referrer has deemed them not appropriate, please detail whom and why:				
Has the **client** been **supported** with **Information and Advice** around the assessment/safeguarding process?	**Yes**		**No**	

Stage the client is at in the required area of support; this will help us triage the case more rapidly ***(Please Mark Only One):***

Stage:	
Beginning of process	
Pre-assessment	
Post assessment	

Area of Support Required *(Please Mark Only One):*

A needs assessment under Section 9	
A carer's assessment under Section 10	
Preparation of a care and support plan or support plan under Section 25	
A review of a care and support plan or support plan under Section 27	
A safeguarding enquiry or Safeguarding Adult Review	

Reason for Community Advocacy Referral *(Not Under the Care Act)*

What is the issue the client wants to access support for? Please provide as much detail as you can:

Consent

Has client consented to this referral?	**Yes**		**No**	
If no have they been made aware of referral? If not why not?	**Yes**		**No**	
If the client is not able to consent, are you giving us instruction?	**Yes**		**No**	

Details of person completing this form		**Who will make the best interests decision** (this is the person the advocate will provide their report to)	
Name:		Name:	
Job Title:		Job Title:	
Team/Organisation:		Team/Organisation:	
Address:		Address:	
Telephone:		Telephone:	
Email:		Email:	

Please detail any risk issues or incidents ONE Advocacy and our staff should be aware of:

Signed: **Date:**

Name (please print): **Relationship to client:**

Send completed form to: ONE Advocacy Derby, c/o Citizens Advice South Derby and City, Stuart House, Green Lane, Derby, DE1 1RS or email to referrals@oneadvocacyderby.org or **fax to 01332 228701.**

For further information visit **www.oneadvocacyderby.org** or call the **Direct Referral line 01332 228748**