Liverpool Advocacy Hub

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CONFIDENTIAL

First Name:		Surname:	
Date of Birth:			
Home Address & Postcode:			
Current location if different from above **(including telephone and ward details)**			
Telephone Number:			
Mobile Number:			
Email Address:			
NHS Number:			
Funding Authority:			
Preferred method of contact:	☐ Phone ☐ Email ☐ Post		

Does this person have any communication needs?	
Please detail any known risks	

CONSENT - Advocacy Operates under the GDPR Guidelines

If the person being referred is deemed to lack capacity, please sign below to say that you are referring in the client's best interest

Does the person have capacity to consent to this referral?	☐ Yes ☐ No
If yes, has consent been obtained?	☐ Yes ☐ No
Signature of referrer:	

Gender:	☐ Male ☐ Female, male at birth ☐ Non-binary	☐ Female ☐ Male, female at birth	☐ Prefer not to say ☐ Other, please specify _____
Pronouns:	☐ He/him ☐ She/her ☐ They/them		
Sexual Orientation:	☐ Asexual ☐ Gay/Lesbian	☐ Bisexual ☐ Prefer not to say	☐ Heterosexual ☐ Other, please specify _____
Client Group:	☐ Acquired brain injury ☐ Carer ☐ Dementia ☐ Long term health condition ☐ Autism ☐ Communication difficulties	☐ Multiple impairments ☐ Older person ☐ Sensory impairment ☐ Substance misuse ☐ Learning disability ☐ Mental health	☐ Neurological conditions ☐ Physical disability ☐ Stroke ☐ Other (please specify) _____
Disability:	☐ Yes ☐ No	Please specify: _____	

Ethnic Origin:	☐ African ☐ Black/Black British ☐ European ☐ Mixed heritage ☐ White Irish ☐ Other, please specify:	☐ Arab/British Arab ☐ Carribean ☐ Gypsy/Roma ☐ Pakistani ☐ White other	☐ Asian/British Asian ☐ Chinese ☐ Indian ☐ White British ☐ Prefer not to say

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Religion:	☐ Atheist ☐ Catholic ☐ Christian ☐ Jewish	☐ Sikh ☐ Buddhist ☐ Hindu ☐ Muslim	☐ Not known ☐ No religion ☐ Other/denomination please specify: _____

Marital Status:	☐ Married/Civil Partnership ☐ Separated ☐ Other, please specify: _____	☐ Single ☐ Living together	☐ Divorced ☐ Widowed

Please provide Referrer and Decision Maker details

	Referrer	Decision Maker
Name:		
Job/Role:		
Organisation/Team:		
Telephone:		
Email:		
Referral Date:		

Advocacy Service Information

Please only complete information specific to the advocacy type you are referring for.

Care Act Advocacy - please complete all below sections for us to be able to triage the referral

Care Act Advocacy ☐		Care Act for Carers ☐	
Assessment ☐	Review ☐	Safeguarding ☐	Support Planning ☐
Will this person have substantial difficulty in being involved with the process?	Yes ☐	No ☐	
Has the client been deemed as having no appropriate person to facilitate the client's engagement in the process?	Yes ☐	No ☐	

Independent Mental Capacity Advocacy (IMCA) - please complete all below sections for us to be able to triage the referral

Serious Medical Treatment ☐	Change in Accommodation ☐	Safeguarding ☐	Care Review ☐
Has the client been assessed as lacking capacity around this issue?	Yes ☐	No ☐	
Has the client been deemed to not have appropriate friends or family who can be consulted?	Yes ☐	No ☐	
Date of capacity assessment:			
Who completed the capacity assessment?			
Any upcoming meeting dates?			

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Independent Mental Health Advocacy (IMHA) - please complete all below sections for us to be able to triage the referral

☐ Section 2	☐ Section 3	☐ CTO	☐ Guardianship	☐ Other: _____

Section start date:	
Ward:	
Any upcoming meeting dates?	

Generic Advocacy

Is the issue regarding health or social care?	Yes ☐	No ☐
Is this person an informal patient on a psychiatric ward?	Yes ☐	No ☐

Health Complaints

Is the issue regarding NHS services?	Yes ☐	No ☐

REFERRAL REASONS (Please add any relevant information)

Please return this form to -
Email: **referral@liverpooladvocacyhub.org.uk** Phone: **0300 3030 629**
Post: **Liverpool Advocacy Hub n-compass, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF**
Website: **www.liverpooladvocacyhub.org.uk**