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

Ethnic Origin	African	Arab/British Arab	Asian/British Asian
	Black/Black British	Carribean	Chinese
	European	Gypsy/Roma	Indian
	Mixed Heritage	Pakistani	White British
	White Irish	White other	Prefer not to say
	Other (please specify)		

Religion	Athiest	Sikh	Not known
	Catholic	Buddist	No religion
	Christian	Hindu	Other/denomination (please specify)
	Jewish	Muslim	

Marital Status	Married/Civil Partnership	Single	Divorced
	Separated	Living together	Widowed
	Other (please specify)		

Please provide Referrer and Decision Maker details

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

Advocacy Service Information

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

Carer 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 clients engagement in the process?			Yes No

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Independent Mental Capacity Advocacy (IMCA)

Serious Medical Treatment	Change in Accommodation	Safeguarding	Care Review
Has this client been deemed to not have appropriate friends or family who can be consulted?			Yes No
Has this person been assessed as lacking capacity around this issue?			Yes No
Date the capacity assessment was undertaken?			
Who completed the capacity assessment?			

Independent Mental Health Advocacy (IMHA)

Section 2	Section 3	Community Treatment Order	Other
What ward are they currently on?			
When did the section begin?			

General Advocacy

Is the issue regarding health or social care?	Yes No
Is the issue in relation to Social Care Complaints	Yes No

NHS Health Complaints

Is the issue regarding NHS services?	Yes No

Referral Reason. Please add any relevant information inc. meeting dates

Please return this form to -
Email: **referral@westmorlandandfurnessadvocacyhub.org.uk** Phone: **0300 3030 209**
Post: **Cumberland IMHA Hub, 1 Edward VII Quay, Navigation Way, Preston, PR2 2YF**
Website: **www.westmorlandandfurnessadvocacyhub.org.uk**

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