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# Barnet, Enfield and Haringey Advocacy Referral Form

## For referrals from professionals

#### *All data supplied to us in this form will be processed in accordance with our* [*Privacy Notice*](https://www.voiceability.org/privacy-policy/)*.*

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| **About the person** | | | | | | | | | | | | |
| **Name** | |  | | | | | | | | | | |
| **Has the person being referred requested an advocate?** | | | | Yes  No | | **Has the person agreed to this referral?** | | | | | Yes  No | |
| **Current place of residence**  *(at date of referral; please include ward name if applicable)* | | | |  | | | | | | | | |
| **Home address** *(if different)* | | | |  | | | | | | | | |
| **Telephone number** | | | |  | | **Mobile number** | | | |  | | |
| **Date of birth** | | | |  | | | | | | | | |
| **Email address** | | | |  | | | | | | | | |
| **Does this person have capacity around the referring issue?** | | | | | | Yes  No  Fluctuating | | | | | | |
| **Is the referred person an informal carer?** | | | | | | Yes  No | | | | | | |
| **Does the person have the following?** | | | | | | | | | | | | |
| Learning Disability |  | | Mental Health Difficulties | | | | |  | Dementia | | |  |
| Acquired Brain Injury |  | | Sensory Impairment | | | | |  | Physical Impairment | | |  |
| ASD |  | | Neurological Condition | | | | |  | Stroke | | |  |
| Profound and Multiple Learning Disabilities |  | | Physical Ill Health | | | | |  | Substance Misuse | | |  |
| Eating Disorder |  | | Other | | | | |  |  | | |  |
| **Risks** (the size of this box will expand as you type). *Please detail any information needed to ensure the safety of the advocate and the referred person during the advocacy.* | | | | | | | | | | | | |
| **Support needs** (the size of this box will expand as you type). *Please detail any support needs the advocate needs to be aware of to provide advocacy, e.g. any long term condition, language or preferred communication method.* | | | | | | | | | | | | |
| **About the referrer (you)** | | | | | | | | | | | | |
| **Print name** | | | | |  | | | | | | | |
| **Position/relationship to person** | | | | |  | | | | | | | |
| **Organisation** | | | | |  | | | | | | | |
| **Team and/or department** | | | | |  | | | | | | | |
| **Telephone number** | | | | |  | | | | | | | |
| **Mobile number** | | | | |  | | | | | | | |
| **Email** | | | | |  | | | | | | | |
| **Signature (Referrer)** | | | | | | | **Time** | | |  | | |
| **Date** | | |  | | |

Now please complete **EITHER** IMCA **OR** 1.2A Representative **OR**   
Care Act questions below. If you are not sure which applies, call our Helpline for advice on 020 8900 2221.

#### *Please note, Care Act advocacy is available in Enfield and Haringey only, not Barnet.*

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| If you know you are requesting an IMCA | | | | | |
| **What is the Best Interest Decision to be made?** | | | | | |
| Serious medical treatment |  | Safeguarding adults | | |  |
| Long-term accommodation |  | Care review | | |  |
| *Care Act Advocacy can often be more appropriate than IMCA for referrals about Care reviews and Safeguarding adults – contact us on 020 8900 2221* *if you would like to discuss this.* | | | | | |
| **Please describe the decision** (the size of this box will expand as you type) | | | | | |
| **What is the decision maker’s name and contact details?** | | |  | | |
| **Is there a date a decision needs to be made by?** | | | Yes  Date       No | | |
| **Are there any key meeting dates?** | | |  | | |
| **Does the referred person have any family or friends appropriate to consult?** | | | | Yes  No | |
| If yes, please outline why an advocate is still required | | | | | |
| **Has a 2-stage functional assessment of capacity been carried out?** *(Please send the capacity assessment to us once complete. However, you don’t need to wait on that to send us this referral form.)* | | | | Yes  No | |

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| If you know you are requesting a Rule 1.2A Representative **(Formally known as a 3A Representative)** | | | | |
| **Social worker’s contact details** | |  | | |
| **LCC legal contact details** | |  | | |
| **Hearing date** |  | | **COP24 Witness Statement deadline date** |  |

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| If you know you are requesting a Care Act advocate  (We offer Care Act advocates in Enfield/Haringey only) | | | | |
| **Is the referral for** | | **Referral Category** | | |
| An adult with care & support needs |  | Assessment | |  |
| A carer with support needs |  | Planning | |  |
| A young person with care & support needs |  | Review | |  |
| A young carer with support needs |  | Safeguarding | |  |
|  |  | Advice and Information | |  |
| **Does the person have an appropriate individual to support them?** | | | Yes  No | |
| **If yes, please outline why an advocate is still required** (the size of this box will expand as you type) | | | | |

# Optional questions

Before you send the form, please complete the equal opportunities information on the next page if you are able. However, we can process referral forms without the optional information.

# Returning this form

### Please return the completed form by email to [BEH@voiceability.org](mailto:BEH@voiceability.org), by fax to 020 8330 6622 or by post to VoiceAbility, Unit 1, The Old Granary, Cambridgeshire, CB24 3AR. *(We provide locally based advocates but our Helpline team in Cambridge handle the referral forms.)*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Equal opportunities information (optional) | | | | | | | | | |
| *If you have this information* ***about the person you are referring,*** *please supply it below.* *If you do not have it, leave this section blank.* | | | | | | | | | |
| Gender | | | | | Sexuality | | | | |
| Male | |  | | | Heterosexual / Straight | |  | | |
| Female | |  | | | Homosexual / Gay / Lesbian | |  | | |
| Transgender | |  | | | Bisexual | |  | | |
| Prefer not to say | |  | | | Other/Prefer not to say | |  | | |
| Ethnic origin or background | | | | | | | | | |
| **White British** | | | | | **Mixed and Multiple Ethnic Groups** | | | | |
| English / Welsh / Scottish / Northern Irish / British | | | |  | White and Black Caribbean | | |  | |
| Irish | | | |  | White and Black African | | |  | |
| Gypsy or Irish Traveller | | | |  | White and Asian | | |  | |
| Any other White background, please specify | | | | | Any other Mixed/Multiple Ethnic background, please specify | | | | |
| Asian / Asian British | | | | | **Black / African/ Caribbean / Black British** | | | | |
| Indian | | | |  | African | | |  | |
| Pakistani | | | |  | Caribbean | | |  | |
| Bangladeshi | | | |  | Any other Black/African/Caribbean background, please specify | | | | |
| Chinese | | | |  | **Other Ethnic Group** | | | | |
| Any other Asian background, please specify | | | | | Arab | | |  | |
| **Prefer not to say** | | | | | Any other ethnic group, please specify | | | | |
| **Religious beliefs** | | | | | | | | | |
| No religion |  | | Jewish | |  | Hindu | | |  |
| Christian |  | | Muslim | |  | Prefer not to say | | |  |
| Buddhist |  | | Sikh | |  |  | | |  |
| Any other religion, please specify | | | | | | | | | |