IHCA Professional Referral Form

Professional Referral Form for Independent Health Complaints Advocacy

the advocacy people

This form is for use by Professionals making a referral on behalf of someone who wants help/support making a complaint or is in the process of making a complaint about the NHS or a service provided by the NHS (or is doing so on behalf of someone else).

0 Office Use Only

Case reference

Date referral received

Advocacy service referred to

Advocate/Team

1 Referrer Details

Date of referral

Organisation

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Job Title/Relationship to Complainant

Doctor	Psychiatrist	Ward Manager
Care Manager	Care Home Manager	Team Manager (Health)
Team Manager (Social)	Social Worker (Hospital)	Social Worker (Community)
Nurse (Health Professional)	PALS Team Member	Paid Carer
Healthwatch		

Other (please specify)

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2 Patient Details (if the complainant is making the complaint on behalf of another person, enter the details here, otherwise, skip to section 3 to provide the complainant details)

Title

Date of Birth

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Complainant's relationship to patient (the person the complaint is being made on behalf of)

Is the patient happy for the complainant to contact us and make the complaint on their behalf?

Yes ☐ No ☐ Not Applicable ☐

If not, please explain why (e.g. deceased, lacks capacity, etc.)

Name of Patient's GP

Address

Telephone Number

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3 Complainant Details (this is the person making the complaint, who requires advocacy support)

Title

Date of Birth

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Preferred method of contact

Any		Phone		Mobile	
SMS (Text)		Email		Post	

Does the person making the complaint consent to the referral being made and to The Advocacy People making contact with them?

Yes ☐ No ☐

Name of Complainant's GP

Address

Telephone Number

Location Setting

Own home		Own home (with support)		Supported Living	
Hospital		Care/Nursing Home		Dementia Ward	
Acute Psychiatric Ward		Forensic Secure Unit		Prison	
Homeless		No fixed abode			

Other/Ward Name (if in hospital)

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3 Complainant Details cont.

Is English Spoken?

Yes ☐ No ☐ Not Known ☐

Primary Communication Method

Spoken English	☐	Other spoken language (specify below)	☐
Words/Pictures/Makaton	☐	Gestures/Expressions/Vocalisations	☐
British Sign Language (BSL)	☐	No Obvious Means	☐
Not known	☐		

Other (please specify other spoken languages here)

Does the complainant have one disability which is most relevant to the case? (If not, please leave blank)

Mental Health Condition	☐	Acquired Brain Injury	☐	Serious Physical Illness	☐
Physical Disability	☐	Learning Disability	☐	Cognitive Impairment	☐
Sensory (Visual)	☐	Sensory (Auditory)	☐	Dementia/Alzheimer's	☐
Asperger's/Autistic Spectrum Condition	☐			Unconsciousness	☐

4 Case Details

Which NHS service is the complaint about?

Where is the service located?

Information about the complaint (tell us where and when issues or incidents happened including names where you can)

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4 Case Details cont.

How did this affect the complainant/patient?

If the complaint has already been raised elsewhere, please give details (tell us where, when and about any responses that have been received)

If there are any supporting documents, tell us which (and attach copies to this referral)

What outcome is the complainant expecting by making this complaint? (select all that apply)

Answers to my questions	An apology	Changes to services
Action to put things right	An explanation	

Other (please specify)

We would like to know how the complainant feels at the moment about raising concerns with the NHS.
Once the complaint has reached an end, we hope we can ask the same questions to measure the effectiveness of our work and to find out how useful they have found our advocacy services.

When dealing with the NHS, how often does the complainant feel:

	Never	Rarely	Sometimes	Always
Listened to				
Treated with respect				
Informed				
In control of decisions				
Confident to speak up				

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5 Declaration

In making this referral, I declare that:

- I wish to request Independent Health Complaints Advocacy support from The Advocacy People on behalf of the client.
- I confirm that I have consent from the client to make the referral.
- In accordance with current Data Protection legislation, I agree to The Advocacy People and their delivery partners holding personal information (including information on this form).
- I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

Please email the completed form to: **info@theadvocacypeople.org.uk**
or post to: **P.O. Box 375, Hastings, TN34 9HU**

If you have not received confirmation of this referral within **3 working days**, or you would like to discuss any aspects of a referral, please call **0330 440 9000**.

By requesting advocacy support, you give consent to The Advocacy People sharing information, as required for the purposes of providing the service.
For more information on our Privacy Notice, please ask your advocate or go to www.theadvocacypeople.org.uk/privacy

Confidentiality
Communications between you and The Advocacy People are confidential. We will not divulge any information without your permission unless disclosure is required or permitted by law, e.g. where you tell us something which leads us to believe you or someone else may be at risk of serious harm or abuse or committing a serious criminal offence, where there is a court order for disclosure, or where we would be breaking the law by failing to disclose.

All records are held by The Advocacy People in accordance with current Data Protection legislation.

The Advocacy People