

1.2 Rep Community DoL

Client and Referrer Information



Office Use Only

Case reference

Date referral received

Advocacy service referred to

Advocate/Team

Referrer Details

Date of referral

Organisation

First Name

Last Name

Address

Postcode

Telephone Number

Email Address

Mobile Number

Job Title/Relationship to Client

Social Worker

☐

Social Work Assistant

☐

Team Manager (Social Care)

☐

Care Manager

☐

Administrator

☐

Other (please specify)

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Client and Referrer Information



 Client Details

NHS Number (if known)	Social Services Number (IMCA & ICAA only)
<input type="text"/>	<input type="text"/>

Title	Date of Birth
<input type="text"/>	<input type="text"/>
First Name	Last Name
<input type="text"/>	<input type="text"/>
Known as (alias)	Pronouns
<input type="text"/>	<input type="text"/>
Permanent Address	Postcode
<input type="text"/>	<input type="text"/>
	Telephone Number
	<input type="text"/>
Email Address	Mobile Number
<input type="text"/>	<input type="text"/>
Current Address (if different from above)	Postcode
<input type="text"/>	<input type="text"/>
	Telephone Number
	<input type="text"/>

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 (please specify)	<input type="text"/>				

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Client and Referrer Information



Client Details cont.

Preferred method of contact

Any	☐	Phone	☐	Mobile	☐
SMS (Text)	☐	Email	☐	Post	☐
No Direct Contact	☐				

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 client identify as having a disability?

Yes ☐ No ☐ Not known ☐ Prefers not to say ☐

Does the client have a diagnosed or recognised disability? (select all that apply)

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	☐
Other (please specify)					

Is there one disability which is most relevant to the case? (If there is not, 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	☐

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Equality & Diversity Monitoring Information (optional)



This information helps us to ensure we're reaching everyone equally.

Military Connection

Serving	☐	Veteran	☐	Carer relationship	☐
None	☐	Not known	☐	Prefers not to say	☐

Gender

Male	☐	Female	☐	Trans (Male to Female)	☐
Trans (Female to Male)	☐	Not known	☐	Prefers not to say	☐
Other (please specify)					

Sexual Orientation

Lesbian	☐	Gay Man	☐	Heterosexual	☐
Bisexual	☐	Questioning	☐	Not known	☐
Prefers not to say	☐				
Other (please specify)					

Marital/Civil Partnership Status

Single	☐	Co-habiting	☐	Married	☐
Civil Partnership	☐	Divorced/Dissolved	☐	Separated	☐
Widowed	☐	Surviving (Civil Partnership)	☐	Not known	☐
Prefers not to say	☐				

Belief

Buddhist	☐	Christian	☐	Hindu	☐
Jewish	☐	Muslim	☐	Sikh	☐
No Religion	☐	Not known	☐	Prefers not to say	☐
Other (please specify)					

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Equality & Diversity Monitoring Information (optional)



Ethnicity

Asian/Asian British

Indian	☐	Pakistani	☐
Chinese	☐	Bangladeshi	☐
Other (please specify)			
<input type="text"/>			

Black/Black British

African	☐
Caribbean	☐
Other (please specify)	
<input type="text"/>	

White

British	☐
Irish	☐
Gypsy/Traveller	☐
Other (please specify)	
<input type="text"/>	

Mixed

White & Black Caribbean	☐
White & Black African	☐
White & Asian	☐
Other (please specify)	
<input type="text"/>	

Other

Arab	☐
Other (please specify)	
<input type="text"/>	

Not known	☐
Prefers not to say	☐

Does the client identify as Cornish?

Yes	☐	No	☐	Not known	☐
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1.2 Rep Community DoL



Case information

In making this referral, we assume you are preparing an **application to the Court of Protection** for a **Community DoL** because the person:

- is living somewhere other than a care home or hospital
- has been assessed as lacking capacity to consent to this
- does not have a friend or family member who can take on the role

The current care and support plan and draft COP11 (if available) should be attached to this referral.

Depending on the geographical location of your client, you may be asked to complete a Spot Purchase Agreement for payment of our work.

If this is not the case, please call us on 0330 440 9000 and ask to speak to the local team.

● **Risks** - this section **must** be completed, even if there are no known risks.

The safety of our staff and the people we work with is of paramount importance. Please provide any known risks or state 'no known risks'.

● Case Details

Is this a first referral or a renewal?

First ☐ Renewal ☐

Which have been attached? (these should both be attached if available)

Care and Support Plan ☐ COP 11 ☐

Who should we contact to make arrangements to visit the client?

Name

Role

Email

Phone

1.2 Rep Community DoL

Case information



● Case Details cont.

In preparing court application, the 1.2 Rep will expect to:

- have initial discussion with professionals and visit the client
- attend a Best Interests meeting (N.B. if this has already taken place, the 1.2 Rep should be provided with the minutes and most recent care and support plan)
- prepare a COP24 Witness Statement
- prepare the COP11 Annex C

Our remit to visit whilst awaiting the Court Order varies according to our contract with the relevant local authority. Please contact us if you would like to discuss.

Whilst the Court Order is in place, the rep will visit every 6-8 weeks. Please enter an alternative frequency if required.

Around 8 weeks prior to the end of the Court Order, the 1.2 Rep will notify the applicant authority that a further referral is needed to begin the renewal work and a new case will be created.

● Declaration

In making this referral, I declare that:

- I wish to instruct a Community DoL/1.2 Rep.
- I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
- 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 **2 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 Policy, 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.

The Advocacy People