

ICAA Referral Form

Referral Form for Independent Care Act Advocacy



Advocacy and the duty to involve

Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

When does the advocacy duty apply?

The advocacy duty will apply from the point of first contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding review. If it appears to the authority that a person or their carer has care and support needs, then a judgement must be made as to whether that person has substantial difficulty in being involved. If they do, and there is not an appropriate individual to support them, an independent advocate must be appointed to support and represent the person for the purpose of assisting their full involvement.

0 Office Use Only

Case reference	Date referral received
Advocacy service referred to	Advocate/Team

1 Referrer Details

Date of referral	Organisation (if referring on a professional basis)
First Name	Last Name
Address	Postcode
	Telephone Number
Email Address	Mobile Number

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2 Referrer Details

Job Title/Relationship to Client

Doctor	Psychiatrist	Ward Manager
Care Manager	Care Home Manager	Team Manager (Health)
Team Manager (Social)	Social Worker (Hospital)	Social Worker (Community)
Nurse (Health Professional)	Administrator	
Other (please specify)		

3 Client Details

Title Date of Birth

First Name Last Name

Permanent Address Postcode

Telephone Number

Email Address Mobile Number

Current Address (if different from above) Postcode

Telephone Number

Preferred method of contact

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

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3 Client Details cont.

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)		

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)		

Military Connection

Serving	Veteran	Carer relationship
No	Not known	Prefers not to say

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3 Client Details cont.

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

Gender

Male	Female	Trans (Male to Female)
Trans (Female to Male)	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		

Sexual Orientation

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

Belief

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

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3 Client Details cont.

Ethnicity

Asian/Asian British

Indian Pakistani
Chinese Bangladeshi
Other (please specify)

Black/Black British

African
Caribbean
Other (please specify)

White

British
Irish
Gypsy/Traveller
Other (please specify)

Mixed

White & Black Caribbean
White & Black African
White & Asian
Other (please specify)

Other

Arab
Other (please specify)

Not known
Prefers not to say

Does the client identify as Cornish?

Yes No Not known

4 Case Details

Local Authority (Council of referrer's location)

Referral reason

Adult needs assessment	Carer's assessment
Preparation of care and/or support plan	Review of care & support plan
Review of carer's support plan	Child needs assessment (transition)
Young carer assessment	Child's carer's assessment (transition)
Safeguarding enquiry	Adult's safeguarding review

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4 Case Details cont.

Information about the client's current circumstances and need for advocacy support

Statutory referral eligibility

Only paid professional support available

Family/friend have vested interest

No friend/family available

No preferred friend/family available

The Appropriate Person is in conflict/dispute with the Local Authority

Other (please specify)

Does the client have substantial difficulty in: (select all that apply)

Understanding relevant information

Using or weighing up information

Retaining information

Communicating (views, wishes and feelings)

Are you satisfied that this referral meets the criteria under the Care Act? (and is in the best interests of the client if they have not been made aware or not given their consent)

Yes

No

Is the client aware of this referral?

Has the client consented to this referral?

Yes

No

Yes

No

Is the client subject to Mental Health Act section 117 Aftercare?

Yes

No

Not known

Has an Independent Mental Capacity Advocate (IMCA) been previously involved?

Yes

No

Not known

Enter dates, times and venues of any important meetings or other deadlines

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4 Case Details cont.

Enter the name, relationship and contact details of others to be involved or consulted

If you are aware of any records of the person's wishes, give details

If there are any risks we should be aware of, give details (otherwise state 'no known risks')

Emergency contact information

Name

Relationship to client

Phone

5 Declaration

In making this referral, I declare that:

- I declare that I wish to instruct an Independent Care Act Advocate.
- I am providing this information and making this referral in relation to the Care Act 2014.
- 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

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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.

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

The Advocacy People