Swindon Advocacy Movement
Swindon Advice and Support Centre
Sanford House
Sanford Street
Swindon
SN1 1QH
Telephone on 01793 542575/616562
Fax Number 01793 423124

CARE ACT REFERRAL FORM

Client Details

Name:					
Date of Birth:					
Address:			**Accommodation Type:**		
			Home Owner		
			Living with Family		
			Social Housing Tenant/Council House		
			Private Tenant		
			Supported Housing		
			Hostel		
			Hospital		
			Other		
G P Name: **Address:** **Telephone Number:**			Current location of client (if not at home address)		
Children under 18:	Yes: Number:		No:		
Carer:	Yes:	No:	**Do they have a Family Carer:**	Yes:	No:
Personal Budget:	Yes:	No:	**In Receipt of Benefits**	Yes:	No:
Referred By:			**Position:**		
Telephone Number:			**Email:**		
Agency:					
Other People involved in clients life:					
What is the best way for us to contact the client?					
Has this person agreed for this referral to be made			Yes:	No:	

A. Statutory Advocacy under the Care Act 2014 ☐			
Must meet the following criteria – please tick one of the following			
Adults who need care and support		Carers of Adults (including young carers	
Carers of children in transition		Children who are approaching the transition to Adult services	
Undergoing the following – please tick which applies			
Care Assessments		Care and Support Planning	
Care and Support Reviews		A Safeguarding Enquiry	
A Safeguarding Adult Review			
What is the nature of the client's substantial difficulty please tick which applies?			
Communicating their views wishes or feelings?		Retaining information?	
Using or weighing up information?		Understanding relevant information?	
Please detail any other information regarding the persons difficulty in being fully involved within the processes:			
Are there any family or friends who can act as an appropriate person?			
Or is there a disagreement between the LA and appropriate person, and they both agree an advocate would be beneficial? Yes/No			
Or is an appeal against the LA decision being made? Yes/No			
Is a placement being considered in NHS funded provision in a hospital (4 weeks +) or a Care Home (8 weeks +) Yes/No			
Please give details of advocacy need:			

Risk Assessment:
This section needs to be completed in order for us to provide a service to the client. Please indicate below anything in the client's history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home.
Any known mental health issues:
Any behaviours we need to know about:
Any known risks in lone working/visiting at home i.e. friends, family, history etc:
Any particular health needs i.e. Epilepsy, Asthma etc:
Any particular communication needs:
Any other details we need to be aware of:

In accordance with the Data Protection Act 1998, all information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without express consent from the client.

☐ Please tick here if you would like to go on our mailing list for AGM etc

Signed (Client) _____ Date _____

Signed (Referrer) _____ Date _____

"Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment"

Please send the above referral to:

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SN1 1QH

Telephone Number 01793 542575/616562, Fax 01793 423124
Email: info@swindonadvocacy.org.uk (please send password protected)

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EQUAL OPPORTUNITY MONITORING FORM

Swindon Advocacy Movement is committed to managing diversity and ensuring equality of opportunity for all. We will treat all cases fairly and equally in all aspects of their race, disability, gender, age, religion or belief, sexual orientation, marital status, pregnancy, maternity and sex.

In order to ensure the continued development of our Equal Opportunities and Diversity Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details							
I am:	Married	Single	Divorced/ Separated	Widowed	Prefer not to say		
My Gender Is:	Male	Female	Transgender	Prefer not to say			
Sexuality:	Heterosexual	Homosexual	Lesbian	Bisexual	Prefer not to say		
My Religion is:	Christian	Muslim	None	Prefer not to say			
	Sikh	Hindu	Other (please state)				
Employment Status:	Employed	Unemployed	Registered Disabled	Retired			
Age Groups	16-24	25-34	35-44	45-54	55-64	65+	Prefer not to say
I am	Pregnant	Or Maternity	Prefer not to say	Not applicable			
Post Code:							

Ethnicity:			
White British		Asian – British or Indian	
White Irish		Asian – British or Pakistani	
White Other		Asian – British or Bangladeshi	
Please specify;		Any other Asian background	
Mixed – White & Black Caribbean		Black – British or Black Caribbean	
Mixed – White & Black African		Black – British or Black African	
Mixed –White & Asian		Other Black	
Mixed – White Other		Oriental - Chinese	
Any other mixed background		Oriental – Other	
		Not Established	

Disability:

Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? **Please tick**

Yes		**No**		**Prefer not to say**	

If you have answered yes to the question above, how would you best describe your disability. **Please tick all that apply**

Hearing		**Speech**		**Physical**		**Mental Health**	
Visual		**Mobility**		**Learning**		**Other**	