Swindon Advocacy Movement
Sanford House
Sanford Street
Swindon
SN1 1HE
Telephone on 01793 542575/616562
Fax Number 01793 423124

STATUTORY ADVOCACY REQUEST

Client Details

Name:			
Date of Birth:		**Contact telephone no:**	

Home address: **Current location of client (if not at home 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:**					
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:			
What is the best way for us to contact the client? (If appropriate)			
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 or all that apply?			
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/capacity 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			
B. Statutory Advocacy under the Mental Capacity Act 2005 ☐			

PLEASE ATTACH CAPACITY ASSESSMENT TO THIS REFERRAL FORM (decision specific)					
Name, position and contact details of the profession who had decided the referred person lacks mental capacity to make a decision on the referral issue:					
Has a 2 stage functional assessment of capacity carried out?			***Yes*** ☐ ***No*** ☐		
Family and Friends					
Does the referred person have a family?	***Yes*** ☐ ***No*** ☐		**And/or friends?**	***Yes*** ☐ ***No*** ☐	
Are the person's family/friends appropriate to be involved in the best interest decision?			***Yes*** ☐ ***No*** ☐		
If no, what is the reason the family/friends are not involved?					
What is the decision to be made about? (Please tick)	**Accommodation**		**Serious medical treatment**		
Is the person the alleged perpetrator through safeguarding enquiries?	***Yes*** ☐ *Please note victims of safeguarding enquiries will now be covered under the Care Act*				

When does the decision need to be made by?		**What is the projected discharge date?**	
When are any deadlines or important meeting dates?			
Support needs- Please detail			

Risk Assessment: Please complete for all referrals

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:

Here at SAM we take your privacy seriously and will only use your personal information to provide you with independent advocacy in accordance with the General Data Protection Regulations.
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 your express consent. Please see our Privacy Notice on request or on our website.

☐ 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: Swindon Advocacy Movement, Sanford House, Sanford Street, Swindon SN1 1HE
Telephone Number 01793 542575/616562, Fax 01793 423124
Email: info@swindonadvocacy.org.uk (please send password protected)
**** Referral Receipt** SAM will confirm receipt of all referrals within 24 hours. Please contact SAM if you have not received confirmation of receipt.**

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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						
Are you Married or in a Civil Partnership	Yes	No	Prefer not to say			
Gender:	Male	Female	Transgender	Prefer not to say		
Sexual Orientation:	Heterosexual	Gay man	Gay woman/ Lesbian	Bisexual	Prefer not to say	
Religion:	Christian	Muslim	None	Buddist	Jewish	
	Sikh	Hindu	Other (please state)	Prefer not to say		
Employment Status:	Employed	Unemployed	Registered Disabled	Retired	Student	Prefer not to say
Age Groups	Under 16	16-24	25-34	35-44	45-54	55-64	65+	Prefer not to say
Post Code:	**Prefer not to say**						

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	
Prefer not to say		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	