



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: <input type="checkbox"/>		No: <input type="checkbox"/>	
		Number:			
Carer:		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Do they have a Family Carer:	
				Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Personal Budget:		Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	In Receipt of Benefits	
				Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
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: <input type="checkbox"/>	No: <input type="checkbox"/>

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	<input type="checkbox"/>	Carers of Adults (including young carers)	<input type="checkbox"/>
Carers of children in transition	<input type="checkbox"/>	Children who are approaching the transition to Adult services	<input type="checkbox"/>

Undergoing the following – please tick which applies

Care Assessments	<input type="checkbox"/>	Care and Support Planning	<input type="checkbox"/>
Care and Support Reviews	<input type="checkbox"/>	A Safeguarding Enquiry	<input type="checkbox"/>
A Safeguarding Adult Review	<input type="checkbox"/>		<input type="checkbox"/>

What is the nature of the client’s substantial difficulty please tick which or all that apply?

Communicating their views wishes or feelings?	<input type="checkbox"/>	Retaining information?	<input type="checkbox"/>
Using or weighing up information?	<input type="checkbox"/>	Understanding relevant information?	<input type="checkbox"/>

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 <input type="checkbox"/>	No <input type="checkbox"/>	
Family and Friends			
Does the referred person have a family?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	And/or friends? Yes <input type="checkbox"/> No <input type="checkbox"/>
Are the person’s family/friends appropriate to be involved in the best interest decision?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If no, what is the reason the family/friends are not involved?			
What is the decision to be made about? (Please tick)	Accommodation <input type="checkbox"/>	Serious medical treatment <input type="checkbox"/>	
Is the person the alleged perpetrator through safeguarding enquiries?	Yes <input type="checkbox"/> <i>Please note victims of safeguarding enquiries will now be covered under the Care Act</i>		

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		
					4	5	4			
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							